The Massachusetts Health Care Task Force

Final Report to the Task Force
From the Co-Chairs and Working Groups

D R A F T

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One Ashburton Place, 21st Floor
Boston, MA 02108

EXECUTIVE SUMMARY

The Massachusetts Health Care Task Force and the Working Groups associated with it were created by the highest political leaders in the Commonwealth at a time of extreme uncertainty and financial turmoil in health care. The Task Force and Working Groups were charged with performing a comprehensive review of the health care system and with providing a common basis in fact and understanding upon which state leaders could base policy decisions. For the first time, the state's top leaders gathered regularly with prominent leaders in health care and other stakeholders to analyze and discuss the complex issues and challenges facing our health care system. The analysis of the Working Groups and discussions with the Task Force have helped shape health policy during the last twenty months, resulting in concrete interventions as described in the Final Report. The process has also succeeded in bringing public and private leaders in health care closer together, which bodes well for continued thoughtful and informed policy development.

This Draft Final Report is presented to the Massachusetts Health Care Task Force by its Co-Chairs and the Working Groups, whose reports, presentations and deliberations are summarized herein. This Executive Summary is a brief overview of some of the main points from the Draft Final Report. It is not a summary of all the issues, observations or recommendations in the body of the Final Report and in the Working Group Reports themselves, which are incorporated into the Final Report as attachments.

The Working Groups' analyses spanned a variety of issues relating to health care. Because the Working Groups and the Task Force were convened by state government, they have focused on state government policies and interventions. Because of the close inter-relationship between public and private actors in the health care system, the actions of one group affect system conditions and actions by the other group. Interventions designed to address a particular issue may have unforeseen negative effects on other issues or on other actors within the system. Continuous monitoring, collaboration and re-evaluation of policies are called for and will continue to be required.

The System as a Whole

The rapid rate of increase in aggregate health care costs in recent years is a significant problem for the continued viability of the Massachusetts health care system. Although revenue flowing into the system has increased in the last several years and many payers and some providers are more financially stable than they were, conditions have not improved for all. Aggregate costs are increasing rapidly, and additional revenue for health care expenditures is scarce in both the public and private sectors. If costs continue to increase, employers, consumers and the state will not be able to pay for health care coverage under existing arrangements. More people are likely to lose coverage, and access could become more problematic.

Health care cost increases are resulting from a variety of forces. Patient volume shifts towards more expensive settings such as teaching hospitals, hospital outpatient departments, and hospital emergency rooms and away from comparatively less expensive settings such as community hospitals and community-based physician offices. These trends are contributing to financial distress among some community hospitals and increasing the spending levels for o Medicaid. . Concerted and collaborative public and private efforts to encourage a greater percentage of care being provided at lower-cost, clinically appropriate sites of care would help constrain the rate of health care cost increases for both the state and for private payers, and should be actively pursued. In addition, wherever possible, unnecessary expenses in the system should be identified and eliminated. Examples of areas for public and private action and planning include:

- Economic incentives for providers and consumers to incorporate cost-consciousness into their decisions about care;
- Comparative data analysis and reporting on cost, quality and efficiency of providers;
- Quality improvement initiatives, which will also improve cost-effectiveness of care; and

- Administrative simplification, including collaborative HIPAA compliance strategies as well as coordination and streamlining of government-imposed regulatory complexity.

Increasing Revenue to Support the System

Controlling cost increases is an important goal, but more will be required to restore financial stability to the system. It is likely that more revenue flowing into the system will be needed. The question of how much of that additional revenue should come from employers through health insurance premiums, from consumers through cost-sharing mechanisms, and from the state through higher Medicaid payments or other mechanisms, will require continuous monitoring and adjustment, because increases in payment from any sector will have effects on other issues.

- The Finance Working Group has recommended that the Medicaid program increase its rates to hospitals and nursing homes. . But if those rate increases o come at the expense of other important areas of state spending, possibly even Medicaid enrollment, the net result for providers might not be positive.

- Similarly, private payers in Massachusetts have paid less in relation to costs than in any other state in recent years. But the trend in the last two years has reversed e, as double-digit premium increases have become the norm. . Although our HMOs and some providers appear to have improved their financial positions as a result, some providers have seen less of an impact. And, available resources for continued rate increases are limited as corporate profits continue to be low. In the face of further increases, employers may reduce or drop coverage and are likely to shift costs to consumers.

- As consumers face increasing out-of-pocket costs, they may be unable to afford insurance coverage and numbers of uninsured may rise. That would result in

decreased access to services and increased financial pressure on providers and on the Uncompensated Care Pool.

Recognizing these inter-relationships, the Finance Working Group recommended that the state pursue a multi-pronged strategy that combines rate increases necessary to recognize an appropriate proportion of provider costs; re-evaluation and adjustment to Medicaid payment formulas that may not be appropriate to current conditions; targeted assistance to sustain needed providers in the short term; increased regulatory authority in the insurance arena; and increased monitoring of financial conditions and trends in the system as a whole. The Access Working Group recommended that the state encourage flexibility in insurance product design to avoid losing private sector coverage in the face of cost increases.

Increasing Monitoring and Reporting

More than revenue increases will be required, however, to maintain a viable system. State government has been increasing and will need to continue to increase its involvement in and engagement with the health care financing and delivery system. As controlling aggregate health care cost increases becomes imperative for the private sector as well as Medicaid, the state will have an important interest in improving efficiency and controlling costs in the health care system overall. As the state explores the appropriate level of involvement in this arena, an important consideration is the role that the health care system plays in driving our state economy. Achieving and maintaining the right level of involvement will require continuous evaluation as government monitoring increases and as leaders consider more active involvement in the system through oversight or regulation.

Recommendations for increased government activity with respect to health care include:

- Increased monitoring and reporting on financial conditions in the health care system, including conditions of payers and providers;

- Increased regulatory authority in the insurance arena;
- Developing measures and reporting on quality of care, cost and efficiency at the provider-specific level; and
- Working collaboratively with the private sector to develop quality improvement initiatives.

In addition, state government may need to provide targeted financial support to providers that are needed to preserve access to essential services or that have the potential to offer lower-cost alternative care settings that may be important for keeping the system more affordable overall. This strategy has been recommended by the Finance Working Group and other and has been pursued over the course of the last two years. It may be appropriate to combine such assistance with increased involvement in system overall. Although the Finance Working Group recommended this kind of government involvement, it also recommended that over time, reasonable fair payment by all payers and appropriate use of lower-cost care settings should be sufficient to sustain the delivery system.

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I. Introduction

State leaders[1] created the Health Care Task Force in the late spring of 2000, shortly after the receivership of Harvard Pilgrim Health Care and in the midst of widespread reports of hospital financial distress. Through the Task Force and its associated Working Groups, they hoped to learn more about the paradox that has vexed the Massachusetts health care system for at least several years: despite the fact that Massachusetts health care expenditures per capita are 30% higher than the national average and higher than those of any other state, prominent participants in the health care system – including our largest health maintenance organizations and hospitals – were in financial trouble. The Task Force convenors had these common goals: to preserve access to the highest quality care for Massachusetts residents; to preserve and stabilize the health care sector of the state's economy; to maintain Massachusetts' position as a health care leader; and to create greater confidence in the system among Massachusetts residents and businesses.

The Task Force's mandate was to conduct a comprehensive analysis of the health care system in Massachusetts; to find facts about the current state of our health care system; to identify problems or weaknesses in the system; to advance possible solutions to identified problems for consideration by executive and legislative leaders; and to provide a forum for discussion of identified problems and possible solutions among health care experts and professionals in which differing views and opinions could be expressed. Consistent with the concern about financial stability that led to its creation, the Task Force has focused particular attention on financial issues. Most meetings of The Task Force included reports from one or more of the Working Groups. These reports were designed to present the most up-to-date information on the subject under review and, where appropriate, the advantages and disadvantages of various options for intervention.[2] In some cases, the Working Groups presented their recommendations on a preferred strategy for action.

[1] The Task Force was created jointly by then-Governor Paul Cellucci, then-Lieutenant Governor Jane Swift, Speaker Thomas Finneran and Senate President Thomas Birmingham. The only document memorializing the Task Force creation is a joint press release. (Attachment __)

The reports, presentations and discussions at Task Force meetings revealed the complex interrelationship of many challenges that confront the patient, the provider, the insurer, the employer and the government. Many identified problems are beyond resolution by state government action alone. Some are beyond short-term solution by any single actor. Others can be alleviated, in the short or long term, by either government or private sector action, or some combination of the two.

Because the Task Force was created to assist state government leaders, the Working Group reports often focused on options for state action, as opposed to private sector actions. The inter-relationship between government and the private sector in health care, however, required that the Task Force consider the effect of actions by one group on the other. For example, one reason that Medicaid hospital payment rates were such a prominent theme during the Task Force is that in Massachusetts, unlike in other states, private payers were no longer paying a "margin" above costs. Thus, private sector payment policy in combination with state payment policy contributed to the financial instability among hospitals, which in turn contributed to the decision by state leaders to convene the Task Force.

One concern in advancing proposals for state government action is that various factors bearing on a particular problem are constantly changing, and a policy change in one area may have unforeseen or undesirable effects in others. The question then is whether a proposed action, even if it improves the particular problem it is intended to alleviate, would in fact improve the delivery of health care overall in the Commonwealth. For example, increasing Medicaid provider payment rates across the board might help to alleviate the financial stress of some providers, but finding the funds to implement substantial increases at this time might require cuts in state spending in other areas – even in Medicaid eligibility. If the number of uninsured residents were to rise substantially (due to program cuts, to employer benefit cuts, or both), uncompensated care would likely become a more prominent source of losses at the provider level, and some providers might see no net gain in their financial position even if Medicaid rates were

[2] A list of the Working Groups and their composition is presented in Attachment __.

increased. In addition, substantially increasing Medicaid provider payments might enable private payers, who as noted have reportedly paid hospitals less on average in relation to their costs than in any other state (Figure 1), to forestall further increases in their payment rates. While this might have a positive effect on the rate of premium increases or insurer financial stability, it would also increase the share of the system supported by state payments and decrease the share supported by private payments.

An argument can be made that if the state were to accept a greater role in financing hospitals through Medicaid, then, in order to protect taxpayers, it should also take a greater role in monitoring or regulating the costs hospitals incur. Whether that result would amount to a net gain to the health care system, to the state's economy, or both, and whether it would lead to further changes, such as increased state regulation of health care or the need to increase state revenue to support health care, depends on political, social and general economic considerations well beyond the mandate of the Health Care Task Force.

This Report, which is a summary of the Working Group deliberations and comments from Task Force members, is submitted with the hope that it will assist state leaders in making assessments and decisions about health care policy. The Report begins with a description of the Task Force's and Working Groups' structure and procedures, an overview of changes in circumstances over the course of the Task Force's proceedings and a discussion about the context in which the Working Groups' analyses of particular issues should be viewed. The second section of the report discusses the health care system as a whole and issues related to the system as a whole, including a summary of reports by the Working Groups on Access, Quality and Administrative Simplification. The third section presents a summary of the reports and recommendations prepared by the Finance Working Group and its analysis of particular sectors of the health care system. Because hospitals are such a significant part of our health care system and because several of the system trends observed relate to hospital utilization, there is some overlap between the discussion in Section II and the discussion of hospitals in Section III.

The Report concludes with reflections on the Task Force process itself and recommendations for future state analysis of the health care system.

A. Task Force Structure and Procedures

The Task Force was convened jointly by then-Governor Paul Cellucci, then-Lieutenant Governor Jane Swift, Speaker of the House of Representatives Tom Finneran, and Senate President Tom Birmingham. No legislation or executive order memorialized the creation of the Task Force, and no detailed mandate was issued. These leaders simply agreed that a concentrated examination of the Commonwealth's health care system was needed to help them understand, from a shared factual basis, the conditions, forces and trends at work in the health care system, so that they would be better positioned to determine what actions or interventions would be appropriate. They asked Professor Stuart Altman of Brandeis University to serve as Co-Chairman and to guide the substantive analysis to be undertaken, and Justice Herbert Wilkins, retired Chief Justice of the Massachusetts Supreme Judicial Court, to serve as Co-Chairman and to guide the procedure for discussion and analysis. Upon the agreement of the Co-Chairmen, the convenors asked a number of health care leaders and other interested parties to participate in the effort, and announced the undertaking in a joint press conference on May 1, 2000.

Four working groups focused on subsets of issues were forming at approximately the same time under the direction of William O'Leary, then Secretary of Health and Human Services, and Jennifer Davis Carey, Director of the Office of Consumer Affairs and Business Regulation. Those groups were the Finance Working Group, the Access Working Group, the Quality Working Group, and the Administrative Simplification Working Group. Each group has presented its findings, analysis of policy options, and where possible, recommendations to the Task Force for discussion. Several guest presentations supplemented the findings and views of the Working Groups and added to the Task Force's discussions. The Task Force Co-Chairmen and convenors agreed at the outset that because of its size and the structure of its membership, which was heavily weighted towards teaching hospital and HMO leaders, the Task Force itself would take

no votes or official "positions" and that it would instead act as a sounding board and forum for discussion of the data, analysis and options reported by the Working Groups.

The Task Force convenors requested an Interim Report at the end of 2000 and a Final Report at the end of 2001. In January of 2001, the Task Force Co-Chairmen submitted an Interim Report outlining the Working Group reports that had been presented to the Task Force as of that date, listing areas that the Working Groups and Task Force Co-Chairmen intended to undertake in the remainder of the Task Force's allotted time, and posing several over-arching questions that underlie much of the analysis and discussion of health care in the Working Groups and the Task Force.

This Final Report follows a similar approach. It summarizes the material presented by the Working Groups to the Task Force throughout its proceedings, and attempts to place that material into a context that has changed dramatically since the initiation of the Task Force. The Finance Working Group, co-chaired by Professor Altman and Secretary O'Leary until his departure in October and by Secretary Robert Gittens since that time, has been the guiding force behind much of the Task Force presentations and discussions, and has assisted in distilling many of the observations in this Final Report.

B. Task Force Overview: 2000 - 2002

Since the work of the Task Force began in early 2000, there have been changes in the relative financial positions of stakeholders in the system. There is reason to hope that our system is more financially stable than it was when our inquiry began, but the potential for continued financial distress and instability remains. Our HMOs, several of which were teetering on the brink of insolvency in early 2000, appear to be in stronger financial shape. (Figure 2) Some hospitals appear to have improved their financial positions, but it appears that others – particularly some community hospitals – are still struggling and may be losing ground. (Figure 3) The nursing home industry is still in financial distress, though some of the national nursing home chains that had entered bankruptcy proceedings during the last two years are working their way through restructuring with

the hope of emerging with more manageable debt burdens and cost structures. (Figure 4) Home heath care providers have seen some relief under the Medicare prospective payment system, but they continue to struggle financially and face the prospect of more Medicare cuts, with no meaningful relief from other payers. Employers, who in early 2000 were just coming out of a period in which health care cost increases had been small for a number of years, have now seen several years of significant annual increases in premiums, with no relief in sight.[3] (Figure 5)

Over the course of its proceedings, the Task Force has been presented with and has discussed several recommendations and policy options that have led directly or indirectly to state actions or other developments affecting the health care system. For example:

- In July 2000, The Task Force discussed the serious financial conditions of nursing homes and their particular problems attracting and retaining direct care workers. Shortly thereafter, the state devoted significant additional dollars to Medicaid nursing home rates, set aside resources for wage increases to certified nursing assistants, and created several programs to improve training and career ladder opportunities for direct care workers.[4]
- In October 2000, the Finance Working Group outlined its recommendation for financial assistance for hospitals, including Medicaid rate increases and targeted relief for hospitals in particular financial distress. The state budget passed in November 2000 included both elements.[5]
- In March 2001, the Finance Working Group analyzed forces exacerbating financial distress at Whidden Hospital in Everett, as an example of urban community hospital distress. That analysis and the Task Force discussion of it supported state leaders who facilitated a resolution that preserved the hospital and critical mental health services.

[3] According to a recent survey by the Division of Health Care Finance and Policy, premiums for family coverage in the greater Boston area have risen by as much as 50% in the last four years, and the employee-paid portion of those premiums has increased by 45% over the same time period. HCFP Massachusetts Employer-Sponsored Health Insurance Survey.
[4] The fiscal year 2001 General Appropriation Act (GAA) included [summary].
[5] The FY 2001 GAA provided for [summary].

- In several meetings, the Finance Working Group stressed the importance of collecting and analyzing financial and utilization information more frequently in order to identify as early as possible financial trends and health plans and institutions facing particularly difficult financial situations. The fiscal year 2002 state budget includes a provision granting the Division of Health Care Finance and Policy express authority to collect certain information on a quarterly basis.
- The Administrative Simplification Working Group recommended that the state develop a statewide HIPAA compliance strategy and that it work collaboratively with the private sector around HIPAA compliance issues through the Massachusetts Health Data Consortium. In 2001, the Commonwealth created a HIPAA Program Management Office in the Executive Office of Health and Human Services to coordinate agency compliance efforts and to interface with the Massachusetts Health Data Consortium, the principal forum for private sector collaboration around HIPAA and many other issues.
- The Quality Working Group recommended that the Commonwealth coordinate its policies and procedures pertaining to medical error reporting and that it develop and disseminate evidence-based best practice guidelines. The fiscal year 2002 state budget created the Betsy Lehman Center for Patient Safety and Medical Error Reduction to fulfill these and other related functions.
- In several reports and discussions, the Finance Working Group observed that consumer incentives could play an important role in tempering the trend of increasing utilization of high-cost teaching hospitals for services that could be provided in clinically appropriate lower-cost settings. The introduction of products that require higher co-payments for services at teaching hospitals than for services at community hospitals could be seen as being consistent with that observation, although those products appear to be focused on cost-shifting rather than being tailored to encourage medically appropriate utilization of teaching hospitals and other settings.

Despite some evidence of increasing financial stability, the increase in dollars flowing into the system through higher premiums and co-payments appears to be having a greater impact on employers and consumers, who are concerned about cost increases, than it is

having on providers, whose financial positions have not (with certain exceptions) improved substantially. Employers are balking at the prospect of continued significant annual premium increases and are questioning whether the mergers and provider re-alignments of the 1990s yielded any cost efficiencies or whether they may have increased costs or masked financial troubles. There is now little available revenue to add to the system from private or public sources, as the economy continues to be sluggish and the state faces revenue shortfalls. And still, health care costs continue to rise with increasing speed.[6] These facts become more troubling in light of the new priority our nation and our Commonwealth must place on public safety. Inevitably, choices will have to be made about allocating resources among competing worthy goals and programs. Even more than might have been the case before September 11, 2001, the situation calls for public and private efforts to reduce the rate of health care cost increases. Forces affecting overall cost increases and possible interventions to counteract the trend are discussed in Section II below.

C. Context: Hospitals, Medicaid and State Policy Priorities

The Task Force and the Finance Working Group spent much of their time studying and discussing hospitals, and within that discussion, devoted particular focus to Medicaid payments to hospitals. The focus on hospitals is appropriate because everyone has the potential to need hospital care and has an interest in preserving access to high-quality hospitals. Further, hospital care accounts for the largest single expense covered by our health insurance premiums. Many Massachusetts hospitals have been in serious financial distress, and maintaining our world-class hospitals is important to our state identity and to our state economy. The focus on Medicaid rates also has been appropriate. The Medicaid rate is one of the most significant vehicles in the state's control to influence financial conditions among hospitals.

[6] Kowalczyk, Liz. "Spending on Health Care Rises 7 Percent. Hospitals, Drug Costs Contribute to Fastest Acceleration in 12 Years" The Boston Globe, January 8, 2002.

These discussions, however, must be put into the context of the health care system overall, the goals and limitations of the Medicaid program, and the state's general position with respect to revenue and expenses. For example, the role of Medicaid in long-term care is larger, both in terms of dollars expended and in terms of its relative importance as a payer, than the role of Medicaid in the hospital system.[7] Massachusetts' nursing homes, in the aggregate, appear to be in at least as much financial distress as the hospitals, and their potential sources of additional revenue are more limited. Publicly financed long term care, currently concentrated in nursing homes, is of the utmost importance to those who need it. For most of these people – largely the poor elderly and people with disabilities – no alternative to nursing home care is readily available at this time.

The role of Medicaid in ensuring access to primary and preventive services is also critically important. Massachusetts has placed prominent emphasis on expanding eligibility for Medicaid to extend health care coverage to many more residents than would have been eligible before the advent of MassHealth. As unemployment rises and the economy remains sluggish, the numbers of people eligible for MassHealth can be expected to rise – which will increase utilization of services and, therefore, Medicaid expenditures, independent of provider rate increases. Moreover, because utilization of services by Medicaid enrollees appears to be concentrated in higher-cost teaching hospitals, the increase in expenditures that arises from increased enrollment (and therefore, utilization) may be steep.

Recognizing this context is important as the Medicaid program and the state's political leaders assess their priorities and policy options. State revenues are declining; health care costs are increasing; Medicaid enrollment, and with it, utilization, are likely to grow. As leaders face pressure for provider rate increases, they will also face pressure to spend limited state dollars on other purposes, including maintaining Medicaid eligibility and service coverage. They will need to evaluate the appropriate role of Medicaid in the

[7] Medicaid represents 14__% of patients and 10% of revenue in the hospital arena, but 72% of patients and 55% of revenue in the nursing home arena.

financing of health care providers, some of which may be in poor financial condition due to business strategies that have not proven effective, such as the acquisition of physician practices by some teaching hospitals and the investment by some nursing homes in services that were once highly-compensated by Medicare that are now not as well-compensated. They will also need to assess the value of accommodating the current trend of greater amounts of care being provider by higher-cost providers, which may increase the cost of care unnecessarily. Finally, they will need to weigh these matters against other important public programs and goals. That challenge has become even greater in light of the need to devote resources to public safety and preparedness that has come into focus since the September attacks on the United States.

The Task Force and the Working Groups, in contrast, focused on health care alone and, within that arena, discussed particular issues in a serial fashion. Although this Report attempts to place many of those issues into context with respect to the health care system, neither the Task Force nor the Working Groups have attempted to prioritize the interventions that are outlined and in some cases recommended. It remains for the state's policy and political leaders to determine where health care priorities fall within the state's overall obligations and which of the health care goals and priorities are the most important.

II. The Massachusetts Health Care System

A. The Cost of the System

Many members of the Finance Working Group believe that the most significant problem facing the Massachusetts health care system is that the gap between costs and revenue, sustained over a period of time, has led to a precarious situation in which a number of our providers have been in prolonged financial distress and some are in danger of closing. If that happens, we could experience problems in access to care for some populations and in some geographic areas, and quality problems for those overwhelmed providers that remain. In addition, if lower-cost and more efficient providers close, then arguably, base

costs of our system of care will be even higher, compared with other systems, than they need to be.

This problem occurs in the context of a health care system that is already the most expensive in the world. In addition, the increases in our health care expenditures over the last several years have been significant. Employers, consumers and public payers may reach the limit of their ability and willingness to pay more for health care before the system reaches financial stability. Individual providers who believe they are already as efficient as they can be[8] may be unable to respond quickly enough to calls for greater efficiency in the system overall. Yet those calls are prompted by trends that are increasing the aggregate costs of the system – such as the trend of more care being provided in more costly hospital settings. As that trend increases health care expenditures, payers (including the state and private payers) may try to resist rate increases that would further escalate expenditures. Closing the cost-revenue gap at the individual provider level simply by demanding more revenue is not sustainable over the long term. Public and private action on both sides of this core problem – increasing revenue flowing into the system and decreasing overall health care costs (or at least the rate of increase in those costs) – will be required to ensure increased stability in the system.

This core problem is a result of the compounded effect of several longstanding characteristics of our health care system, recent changes in revenue streams that support providers, forces driving health care costs nationally, and trends in Massachusetts that are aggravating cost escalation and financial instability. Each of these factors is outlined more fully below.

[8] The cost and efficiency problems of the system as a whole are different from those that pertain to particular providers. For example, several studies have shown that Massachusetts teaching hospitals, compared with similar teaching hospitals in other parts of the country, are not more costly or less efficient (after accounting for regional variation in input costs) than their peers. The same has been shown with respect to community hospitals. See, e.g., The Lewin Group, "An Analysis of Massachusetts Hospitals' Efficiency and Costs," prepared for the Massachusetts Hospital Association, April, 2000.

Longstanding characteristics of the Massachusetts health care delivery system. The Massachusetts health care delivery system has long been characterized by higher costs and lower provider financial margins that most other systems in the country.[9] Compared with national averages, Massachusetts has:

- More teaching hospitals (which tend to be higher cost) as a percentage of hospitals overall.
- Much higher utilization of teaching hospitals.
- Much higher utilization of hospital outpatient departments and somewhat higher utilization of emergency departments.
- Historically lower hospital operating margins.

More specialist physicians and more physicians overall per population. (Figures 6 & 7)

Recent changes in revenue streams. Certain changes in provider payment systems have had pronounced effects in Massachusetts and have contributed to provider financial distress. Those changes include:

- The Balanced Budget Act of 1997 (BBA) cut Medicare payments, affecting hospitals, home health care providers, and nursing homes.
- Cuts in Medicare payment for graduate medical education hit particularly hard in Massachusetts in light of our high percentage of teaching hospitals.
- A number of years ago, hospitals contracted with HMOs for relatively low payment rates, but more recently the HMOs' market share increased markedly to one of the highest managed care coverage rates in the country – which resulted in decreased hospital revenue from better-paying indemnity products and heightened impact of the low payments from managed care plans. The net reduction in private revenue, in relation to costs, has helped focus debate on the appropriate level of Medicaid payments in relation to costs and has raised questions about the appropriate roles of Medicaid and private payers in supporting hospitals.

[9] Research and education costs contribute to total aggregate costs in Massachusetts; these costs are generally paid for by sources other than patient care payments. When these costs are removed, however, Massachusetts health care delivery system costs remain higher than those in most other systems in the country.

These changes have contributed both directly and indirectly to financial stress among different types of providers. For example, as hospitals have become more distressed, they have had limited ability to support other providers, such as community health centers. Even though the BBA did not affect community health centers as directly as hospitals, it did contribute indirectly to their financial stress.

Forces driving cost increases and health care inflation nationally. Forces that are driving health care cost inflation nationally (including in Massachusetts) include:

- Utilization of new and expensive prescription drugs is skyrocketing. (Figures 8 and 9)
- Research and technology continually add costs to care.[10]
- A nursing shortage is causing labor costs to rise faster than payments for services – and still nurses cannot be found to take the positions on the front lines of care. (Figures 10, 11 and 12)
- Demand for hospital inpatient and emergency room services has been increasing rapidly in the last several years – on the heels of a period of lower demand for those services and consolidation in the hospital system. (Figures 13 and 14)

Trends in Massachusetts exacerbating cost increases and financial stress. Trends in Massachusetts that are exacerbating overall cost increases and financial stress include:

- Use of teaching hospitals is increasing, while use of certain community hospitals is declining. (Figure 15) This trend is occurring nationally as well, but it may be having a particularly destabilizing effect on hospitals in Massachusetts. Reasons for the trend are not clear, but they could include changes in the affiliations of community physicians (e.g., purchase of community physician practices by teaching hospitals), education levels of patient populations, travel patterns, and successful marketing by some hospitals.
- The loss of revenue accompanying the shifting patient volume is crippling community hospitals.

[10] Medicare explicitly adjusts for these. MedPAC. "Report to the Congress: Medicare Payment Policy." March 2001.

- Utilization of hospital outpatient services is increasing rapidly, while payment rates for those services have traditionally paid less than cost as a means of encouraging use of lower-cost settings.[11]
- Utilization of emergency rooms is increasing rapidly, in the context of already high use and a decrease in the number of emergency rooms available due to the closure of a number of hospitals in recent years. (Figures 16 and 17)
- Health insurance premium increases in Massachusetts reflect the combined effect of increased provider payments and the need of our largest health maintenance organizations to rebuild their financial reserves after a period of serious instability.
- Premium costs, historically higher in Massachusetts than the national average, have increased more slowly than in the nation as a whole, so that the amount by which our premiums exceed national averages has decreased. It does not appear that the amount by which our costs exceed national averages has similarly decreased. (Figures 18 and 19)

Options

As outlined above, many factors contribute to the high cost of our system and its rapid cost increases. Those factors related to longstanding characteristics of the health care system in Massachusetts and to Medicare payment policy changes will be difficult or impossible to address with the sorts of actions the state has traditionally used or contemplated. The state could regulate private payment rates, but Massachusetts, along with every other state except one, moved away from this policy in the early 1990s and there is not now widespread support for a return to it.[12] The state could increase Medicaid rates as a means of increasing financial stability (discussed in more detail below under "Hospitals"), but such increases are unlikely to have a moderating effect on

[11] As discussed more fully in part III, lower payments for hospital outpatient care are based in part on the theory that much of that care could be provided at lower cost in a physician office or community health center. Unfortunately, there may be areas of Massachusetts where those lower-cost settings are not readily available.

[12] Some members of the Finance Working Group believe that support for rate regulation will grow if patients and revenue continue to concentrate in teaching hospitals.

the rate of cost escalation and they may do little to stabilize many of the hospitals that are in the most severe financial distress. (Figure 20)

The factors contributing most significantly to system cost increases are the trends of increasing use of higher-cost treatments and care settings outlined above: increasing use of teaching hospitals, hospital outpatient departments, and emergency rooms, as well as increasing use of high-cost prescription drugs.

At a general level, options for responding to those trends are:

1. Accept the situation and pay more for care than would be necessary if lower cost settings or treatments were used;

2. Impose restrictions to forcibly redistribute care to lower-cost settings whenever appropriate;

3. Engage in more aggressive regulation of provider activity;

4. Pursue quality-based incentives to encourage effective and efficient care and consumer education to encourage prudent choices;

5. Impose economic incentives to encourage use of lower-cost providers whenever appropriate and support the development of lower-cost community-based care; and

6. Increase monitoring of the system through data collection and analysis and studies, as appropriate.

Each of these is discussed in detail below.

1. Paying More. It is possible that we will eventually make peace by paying more than we do now to support our higher-cost health care system. But simply accepting higher

costs and current trends of increasing use of higher-cost settings and treatments may not be desirable in the long run. As outlined more fully in the discussion of hospital issues below, these trends could lead to two kinds of higher costs: higher treatment costs than necessary for patients who choose higher cost settings when not clinically necessary, and distressed provider support costs if the lower-cost providers that are losing volume are deemed necessary for the preservation of access to certain important services. Also, the shift of patient volume to higher-cost settings could continue and even accelerate. Premiums are already higher in Massachusetts than the national average (Figure 18). Even though the gap between Massachusetts and the national average has narrowed in recent years (Figure 19), Massachusetts employers are still faced with higher costs than their counterparts in other states. (Figure 21) Unchecked continued increases could make Massachusetts an unattractive business venue.

Even if we do adjust to higher system costs, there could be severe consequences for those many people who will lose insurance coverage because it will become unaffordable for them or for their employers, or both. It could also entail serious consequences for state government, which could face increased Medicaid enrollment, increased uncompensated care, and budget pressure to hold down increases in provider payments or to cut benefits or enrollment under Medicaid.

2. Forcible Redistribution of Care. On the other hand, forcibly redistributing care is unlikely to be successful. Managed care tried this approach through coverage restrictions, and the response of the state legislature was to curtail this type of cost-control device. It is unlikely that the state would impose similar restrictions through its regulatory authority. Some members of the Finance Working Group would support redistribution of Medicaid enrollees' care to lower-cost hospitals through program rules (e.g., designating a hospital as the primary hospital provider for Medicaid enrollees in its defined service area, subject to the hospital's ability to provide medically appropriate care).

3. Government Regulation and Planning. Government intervention could also take the form of more aggressive health planning and regulation of provider activity. The state could engage in more cost-focused regulation of permissible provider service mixes and provider relationships, or rate regulation. These kinds of strategies have been tried in the past with mixed results. While some Finance Working Group members would encourage greater government involvement, others are skeptical about the potential of this strategy to improve the situation. Short of regulation, however, it does make sense for a small number of government leaders to engage in planning for actions the government can or might want to take in the event of widespread lack of access due to lack of insurance or lack of available providers. In addition, the state can increase coordination among state agencies in identifying needed and "at risk" providers and in determining whether state financial intervention might be indicated or possible. A related option is receivership legislation that would allow the state to take over a troubled hospital or other provider where deemed necessary, although the interaction between receivership and bankruptcy regimes would have to be explored and clarified. That strategy could prevent severe crises, but also presents difficult judgments about which providers are truly needed and which conditions require such drastic intervention. Many people are skeptical about the state's ability to make these judgments. Others believe that a comprehensive assessment of needed services and providers would help inform the actions of decisionmakers who now face crises with individual providers as they file notices to close services or operations.[13]

4. Quality-Based Initiatives. Employers are exploring several quality-focused techniques with the goal of improving outcomes and reducing overall costs. These include improving information available about quality and cost to encourage consumers to make prudent choices of treatments and providers, and developing incentives for providers to reduce medical errors and overall treatment costs through effective disease management and consistent use of evidence-based medical protocols. The state should explore

[13] Chapter 141 of the Acts of 2000 requires the Department of Public Health to hold a public hearing when a hospital intends to close an essential health service or terminate operations. Although the law gives DPH no authority to prevent such closures, the hearing process has provoked discussions among policy and political leaders about intervention in each case.

whether it can assist lower-cost providers in improving quality of care or educating consumers about the quality they offer through grant or loan assistance, technical assistance, or both. In addition, the state could explore ways to improve the collection and reporting of information about provider quality and cost, with the goal of supporting prudent consumer choices.

5. Economic Incentives. Engaging consumers and providers through incentives may be successful in constraining, to a degree, the rate of cost increases. Employers are pursuing several kinds of incentives, outlined more fully in the discussion of employers below. Economic incentives can be blunt instruments, as is the case with new health plan designs that impose higher co-payments for services delivered at teaching hospitals, even if the teaching hospital setting is clinically indicated. They can also be effective in controlling costs without impairing quality, as with the tiered co-payment systems employed in many drug benefit plans. Economic incentives are worth exploring as a means of influencing consumer choice among clinically appropriate providers. The state has more limited ability to employ consumer incentives with Medicaid enrollees, but should explore whether it is possible to use some financial incentives to encourage choice of lower cost providers where clinically appropriate, without imposing undue burdens on enrollees. The Medicaid program already employs certain provider incentives, such as paying lower rates for hospital outpatient care that could be delivered in lower cost settings. The effectiveness of those incentives has been limited, in part by a lack of sufficient low-cost providers. Nevertheless, the Finance Working Group believes that provider incentives should be part of any Medicaid rate reform plans. An appropriate complement to this strategy would be investment in the development of capacity among lower-cost community-based providers such as physician offices and community health centers.

6. Increased Monitoring. Many Working Group reports and Task Force discussions pointed to the need for more data about the health care system and more state monitoring of trends and conditions. The Finance Working Group recommended increasing the frequency of provider financial reporting and state analysis of those reports, and that policy is being pursued under recently enacted authority, as referenced above. Areas of

particular stress and concern, such as emergency department utilization, may require additional focused data collection and study efforts to develop effective interventions. In addition to recently implemented data collection around emergency department utilization, the state should develop the capacity to design and implement targeted data collection and studies in a short period of time to inform policy and intervention strategies.

Government planning, quality initiatives and economic incentives should be undertaken in collaboration with payers and providers. Even if each individual stakeholder has an interest in protecting patient volume and market share, all stakeholders have a stronger interest in controlling the rate of cost increases so as to preserve the system itself. Appropriate steering of care to lower-cost, clinically appropriate providers may be necessary to ensure that the system remains functional and affordable.

B. Patient Flow Through the System: Emergency Department Overcrowding and Ambulance Diversion

In addition to exhibiting less than cost-efficient use of providers and high costs overall, our health care system appears to be functioning in ways that impede patient flow, as demonstrated by the widely-publicized phenomenon of emergency department (ED) overcrowding and ambulance diversion. The problem raises questions about whether our system has the appropriate resources in the appropriate settings, and about whether resources are being utilized optimally.

The Finance Working Group met several times with Dr. Howard Koh, Commissioner of the Department of Public Health, and several members of Commissioner Koh's Task Force on Ambulance Diversions to discuss the issues. In October, 2001, Commissioner Koh and Dr. Michael McManus, who has drafted an Issue Brief on the topic for the Massachusetts Health Policy Forum,[14] presented to the full Task Force on the issue. The

[14] Massachusetts Health Policy Forum Issue Brief, "Emergency Department Overcrowding in Massachusetts: Making Room in Our Hospitals," June, 2001.

problem is complex and its causes and possible solutions are not clear. Drs. Koh and McManus observed:

- Demand for ED services is increasing.
- Admissions per hospital and per bed are increasing.
- The number of hospital beds in Massachusetts is lower than it has been for many years.
- Ambulance diversion correlates with total hospital occupancy more than with ED volume.
- Hospitals are forced by the pursuit of efficiency toward very high census and controllable patient flow.
- The ED is mandated to treat all arrivals and therefore cannot control its patient inflow. As a result, overall hospital capacity limits show their effects first in the ED (i.e., when the hospital is "full" overall, the ED becomes overloaded because there is no "back door" through which to admit patients requiring inpatient services).

Drs. Koh and McManus concluded that, in light of the fact that fewer EDs attached to fewer hospitals are facing increased demand for ED services, further reduction in hospital and ED capacity would carry the risk that access to ED services would be impaired. Dr. McManus advised that matching variable demand to falling capacity is the new health care challenge, and it will require innovative solutions.

Commissioner Koh's Task Force, in collaboration with the Massachusetts Hospital Association, has already taken helpful steps such as developing "best practices" to help alleviate the problem. The Finance Working Group has supported Commissioner Koh's recommendation that the state sponsor further study of the issue to determine causes and support pilot programs to implement various additional strategies to determine effective ways to ease the problem.

Additional recommendations offered by Dr. McManus and Dr. Koh include the following:

- Determine the true nature of the changing demand for emergency services and encourage access to medically suitable alternatives.
- Develop and support operations management strategies for improving patient flow and relieving ED gridlock.
- Devise a method for ensuring, monitoring and adjusting overall hospital capacity.
- Address workforce shortages.

C. Access

The Access Working Group presented its report on access to health insurance to the Task Force in November of 2000. Plans for a second report on access to care, particularly as affected by the financial condition of hospitals and community providers in various geographic regions, unfortunately did not come to fruition. Instead, due to a combination of factors, including limitations of time and resources, the unavailability of some Access Working Group members, and the considerable overlap between the discussions in the Access and Finance Working Groups, the members of the two groups were merged in late 2000 and the resulting larger Working Group focused on finance issues. The report on access to care, independent of insurance status but as influenced by financial conditions, is a project the state should pursue as part of increased monitoring, agency coordination and planning recommended throughout this report.

At the time of its presentation to the Task Force, the Access Working Group was able to cite dramatic reductions in the number of uninsured residents in the Commonwealth between 1998 and 2000. Those reductions were due primarily to the expansion of the MassHealth program and to the strong economy and low unemployment rates prevalent at the time. Now, of course, the situation is dramatically different. Unemployment is

rising, and Massachusetts can expect increases in the percentage of residents without insurance and increases in MassHealth enrollment.[15]

The Access Working Group noted that lack of insurance is not an insurmountable barrier to receiving care in Massachusetts, as there are many programs here that facilitate access to care for people who do not have insurance or the means to pay for their care. An outline of the programs the Commonwealth sponsors that pay for care is included in the Access Working Group report. Still, increasing access to affordable health insurance is an important goal because insurance coverage facilitates access to care. A person's health insurance status affects the likelihood that he or she will seek health care services.

The Access Group recommended an incremental approach to expanding access to insurance, and described a number of strategies that would further that approach.[16] Among the strategies it recommended for exploration, with financial analysis and additional information, were the following:

1. Expand MassHealth, by income level or category.
2. Combine and streamline state programs, wherever possible, to reduce administrative complexity and confusion.
3. Consider alternative insurance product design, such as high-deductible policies with subsidies to help low-income enrollees meet those deductibles.
4. Tax credits or subsidies to employers or employees, or both, for the purchase of commercial insurance.
5. Consider mandates on employers to offer insurance or on individuals to obtain and maintain insurance.
6. Explore insurance regulation reform, such as revised rate banding requirements or changes to permissible product design, to facilitate the creation of more affordable insurance products.

[15] DHCFP. "Premium Increases Affect Health Insurance Coverage." Analysis In Brief. No. 3: November 2001.

7. Educate employers about the tax advantages of paying for health care through medical savings accounts and flexible spending accounts.
8. "Indirect mandates" by the Commonwealth requiring all its contractors to provide health insurance to their employees (supported by appropriate levels of payment for services by the Commonwealth).
9. Before enacting mandated benefits, assess the impact the mandate would be likely to have on insurance premiums.

The Access Group suggested pursuing several strategies at the same time, because no single approach would succeed in making adequate and affordable insurance available to all residents. In light of substantially changed circumstances, it should be acknowledged that MassHealth expansion is unlikely. State revenues have fallen, Medicaid spending is increasing commensurate with health care cost increases, and MassHealth enrollment is likely to increase without eligibility expansions. Regulatory changes that could permit more affordable insurance products are still worth exploring.

Some Task Force members were skeptical that increasing consumer financial responsibility for care would be wise, even if a plan incorporated higher co-payments or deductibles could be purchased for a lower premium than would be charged for more comprehensive coverage. Others supported the idea of increasing consumer financial responsibility as an important strategy in encouraging cost-conscious choice of provider. That strategy could, in the long term, be an important means of controlling aggregate system cost increases.

At the time of the Access Group's report, the Commonwealth had recently been awarded a state planning grant by the federal Health Resources and Services Administration for the purpose of developing a plan to make affordable comprehensive health insurance accessible for all Massachusetts residents. The final report prepared with that grant is expected in the spring of 2002.

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[16] More fundamental system reform is being considered by a separate group, the Advisory Committee on Consolidated Health Care Financing and Streamlined Health Care Delivery, created pursuant to Section 32 of Chapter 141 of the Acts of 2000.

D. Quality

1. The Quality Working Group.

The Quality Working Group presented two reports to the Task Force and led thoughtful discussions about its findings with respect to quality of care in the Commonwealth and its suggestions for improving quality of care in the system.

The Quality Working Group recommended that the Commonwealth adopt Professor Jon Chilingarian's multi-dimensional definition of quality that is patient-centered and identifies five underlying dimensions: patient satisfaction, information and emotional support, amenities and convenience, decision-making efficiency and outcomes.[17] The Quality Working Group also noted that the Institute of Medicine's definition of quality appears to be the most widely accepted: "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

The following points are findings of the Quality Working Group:

- Though quality means different things to different stakeholders, the various dimensions of quality are definable and can be measured to address various stakeholders' interests.

- There is no automatic direct correlation between health care spending and quality, and the efficient allocation of available resources is more likely to have a positive impact on quality than increased spending alone.

[17] The Quality Group cites the author of this definition and approach: Jon Chilingerian, Chapter 8 "Evaluating Quality Outcomes Against Best Practice: A New Frontier," *The Quality Imperative – Measurement and Management of Quality in Healthcare*, Imperial College Press, 1999.

- Medical errors and less than best practice quality contribute to the financial problems facing the state's health care system, in addition to increasing unnecessary suffering.

- The usefulness of currently available quality information is questionable because provider-specific differences are buried in health plan averages and little information is collected from the outpatient setting, where increasingly more care is provided.

- In general, consumers do not use objective quality information when making decisions about care and providers, relying instead on the assessments of family and friends. There is a need for better consumer education on quality, despite the lack of flexibility in provider choice some consumers have because of restrictions in their health benefit plans.

- Financial and staffing difficulties have prompted particular concern about quality of care in the nursing home industry, where monitoring of quality needs to be vigilant.

- Providing the highest quality of care to each patient and reducing the possibility of error is not always the primary focus of providers today. This is true for many reasons, including the burden of administrative requirements and financial incentives that work against a focus on patient safety.

- Despite exemplary voluntary quality improvement and medical error reduction efforts underway in the Commonwealth (such as the Mass Health Quality Partnership and the Coalition for the Prevention of Medical Errors), culture, finance and practice inhibit the rate of adoption of evidence-based care guidelines, improvements in patient-oriented information technologies and a focus on ambulatory care settings where most care is now provided for people with chronic conditions – especially mental illness.

The Quality Working Group offered several suggestions for state policy development and interventions that would improve quality of care and patient safety in the Commonwealth:

Align state policies and practices to foster quality improvement and error reduction. The state should review regulations, contracts and payment policies to ensure that they focus on patient-centered quality and quality improvement efforts. For example, the Commonwealth should consider providing incentive payments to providers who demonstrate improvements in patient-centered quality, and over time, should consider terminating relationships with providers who do not achieve appropriate levels of quality and error reduction.

Expand and improve data collection and reporting on quality and medical errors, especially in non-acute settings and at the provider-specific level. The state should work with health plans, providers and groups working on medical error reduction, such as the Mass Health Quality Partnership and the Coalition for the Prevention of Medical Errors, to collect and disseminate provider-level profiles of quality of care and errors. These efforts should include the collection and reporting of information from outpatient and office settings. Reporting requirements should focus on the most important areas for improvement, so as to minimize the burden of additional reporting requirements.

Develop and implement evidence-based practice guidelines. Providers, payers and regulators should work together to develop evidence-based practice guidelines and to identify and work to eliminate barriers and resistance to the implementation of those guidelines. As part of this effort, the Commonwealth should develop a method of tracking and reporting on the most commonly occurring medical conditions, and should focus the development and dissemination of evidence-based best practices on these conditions.

Financial incentives should encourage patient-centered quality improvement. The Commonwealth should target financial assistance to health care providers for projects that yield measurable improvements in patient-centered quality (e.g., computerized physician order entry systems). Payment systems in general should include incentives such as bonus payments for providers that demonstrate measurable achievements in patient safety.

Consumer education. The state should coordinate and expand its efforts in consumer education about quality of care. A comprehensive consumer education initiative should incorporate the current periodic publications by the Group Insurance Commission and the Office of Consumer Affairs and Business Regulation.

2. Guest Presentation: Professor Lucian Leape

In June of 2001, Professor Lucian Leape of the Harvard School of Public Health presented to the Task Force some of the findings of the Institute of Medicine (IOM) with respect to medical errors, and offered certain suggestions. The IOM concluded that the cause of medical errors is bad systems, rather than bad people; and that we need to redesign our systems and to make patient safety a national priority.

Professor Leape advised that the focus on systems is important because individuals will, invariably, make mistakes. Errors can be prevented by designing tasks and processes to minimize dependency on weak cognitive functions such as short-term memory and attention. Lessons from "human factors research" offer the following principles for error reduction: avoid reliance on memory; simplify; standardize; use constraints and forcing functions; use protocols and checklists; and avoid fatigue. Current medical culture generally runs counter to many of these principles.

In addition, focusing on systems rather than individuals reduces the "blaming culture," which is singularly ineffective at preventing errors and injuries. That culture also can

lead to dishonesty and cover-up, and it diverts attention away from systems problems and improvements.

Recommendations include:

- Health care professionals should follow best practices, identify unsafe systems, and help change those systems; be honest with patients; and take responsibility for those individuals who are problematic.
- Hospitals and health care organization CEOs should take responsibility for patient safety, because safety is primarily a function of systems.
- The culture in the health care system should change – best practices should be implemented, and systems should be changed, including general systems such as staffing plans that impose burdensome hours and workloads, and specific systems such as computerized physician order entry systems.
- Safety should be part of any health care organization's strategic plan; punishment of individuals for errors should be avoided; safe medication practices should be implemented; and there should be a general hunt for hazards.
- Regulatory policy should focus on safe practices and move away from focusing on individuals, blaming and punishment; it should offer individuals protection against disclosure (provided that "problem" providers are addressed); it should require safety programs in health care organizations; and it should set specific standards (e.g., maximum hours for house staff, staffing ratios, etc.).

3. The Leapfrog Initiative

Although there was not a Task Force presentation focused specifically on the Leapfrog initiative, the Finance Working Group discussed the initiative several times and it is becoming an important force. The Leapfrog Group is an initiative sponsored by the Business Roundtable to increase the quality and therefore the cost-effectiveness of health care. Its members identify hospitals that meet certain specific quality standards – hospitals that (a) employ specially-trained intensivists in their intensive care units, (b) perform more than a threshold number of certain complex procedures each year, and (c)

have implemented computerized prescription order entry systems. Each of these criteria is clearly measurable and is associated with better outcomes. The Leapfrog goal is to improve quality of care and to reduce costs associated with errors or sub-optimal care by steering patients toward providers who meet the criteria associated with higher quality. The Commonwealth's Group Insurance Commission has adopted the Leapfrog principles.

The Finance Working Group supports the effort to encourage adoption of systems that improve quality of care, but is concerned that the Leapfrog criteria are more likely to be met by more expensive and more financially robust teaching hospitals than by community hospitals. The effect of focusing on these particular measures could be to drive even more care to teaching hospitals, even in cases where quality may not be better there than at community hospitals. The Finance Group suggests that the Leapfrog measures be supplemented with outcome information that will also show high quality community hospitals as desirable providers for an array of inpatient services.

There is some tension between recommendations that stress the publication of provider-level quality and medical error information and those that stress confidentiality for individual providers and a focus on systems improvement. The recently created Betsy Lehman Center for Patient Safety and Medical Error Reduction will provide the Commonwealth with a forum for resolving those tensions and pursuing quality improvement initiatives in health care.

E. Administrative Simplification

The Administrative Simplification Working Group was created to develop strategies and suggestions for reducing administrative cost and complexity in the health care system. It did not analyze costs to determine precisely what percentage of health care expenditures relate to unnecessary administrative costs. Instead, it started from the premise that regardless of percentage of health care dollars associated with administrative complexity, participants in the health care system should take steps to reduce it.

The Administrative Simplification Working Group members agreed that "administrative simplification," for the Working Group's purposes, means reducing the degree of complexity and improving the degree of accuracy in the exchange of information among providers, insurers and employers. Principles the Group endorsed encourage electronic communications in exchangeable formats among providers, payers and employers, and also encourage movement towards broadly available Internet-based communications systems. The Group discouraged imposition of state-level standards for electronic communications in health care administrative simplification. It focused on suggesting ways in which the state could help providers, payers and employers comply with federal standards imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and ways to help providers, payers, employers and public agencies use HIPAA compliance efforts to achieve broader administrative simplification gains.

Among the Administrative Simplification Working Group's observations and recommendations were the following:

- The Commonwealth should act as convenor and facilitator rather than regulator with respect to health care administrative simplification. It should also set a good example by simplifying its own processes and pursuing efficient and timely HIPAA compliance.
- HIPAA compliance efforts should be tied to broader administrative simplification efforts.
- The Commonwealth should rely on and work in collaboration with the Massachusetts Health Data Consortium in coordinating private sector HIPAA compliance and administrative simplification efforts.
- The Commonwealth should coordinate its HIPAA compliance efforts in a statewide strategy that serves as a framework for broader administrative simplification in the future.
- The Commonwealth should request health care system participants to submit information periodically showing their progress in support of HIPAA compliance and administrative simplification; a suggested mechanism for this purpose is creation of a

high-level review panel that would meet periodically to hear publicly from payers, providers and other system participants about their efforts, achievements, and challenges.

- Industry performance standards for administrative matters should be developed, and payers, providers and employers should report periodically on the extent to which they meet those standards. Examples of possible standards include instant adjudication of clean claims upon receipt by payers; availability of written explanations of benefits at the point of service; electronic funds transfer options for payment of claims and copayment; and availability of statements of account through the Internet. The Group did not adopt specific standards, recommending instead that the Massachusetts Health Data Consortium lead the effort, with its collaborative operations and information officers' forums, to agree on performance standards that can best leverage HIPAA compliance efforts already underway.
- The Commonwealth should support, directly or by facilitating private funding, experimentation and creativity in the development of administrative simplification approaches through demonstration projects (to develop and test new, low-cost technologies) and centers of excellence (to focus on sustained research and development of technologic solutions that can be used by public and private payers and providers to achieve administrative simplification advances).
- The Commonwealth should focus on developing technology that will help smaller providers and should encourage use of existing technology, including the Internet, among smaller providers.

The Administrative Simplification Working Group members could not agree on a common approach to HIPAA compliance or a set of performance standards to which they were willing to be held. Each Working Group member was constrained by the legacy systems of his or her organization, the need to comply with HIPAA in the most cost-effective way based on those systems, and the need to devote scarce resources to HIPAA compliance in the first instance due to looming federal deadlines and penalties. They did agree in principle that such performance standards would be helpful and would allow them to focus on results rather than adoption of or investment in particular technologies.

An additional aspect of administrative simplification highlighted by some of the Task Force members is the observation that the state, though its various agencies and regulations, imposes unnecessary administrative complexity and paperwork burdens. The recommendation, obviously, is that the Commonwealth evaluate, coordinate and simplify the administrative burdens it imposes on health care sector participants.

III. Sector Financial Conditions and Related Challenges

A. Hospitals

At its first meeting in June of 2000, the Task Force discussed the Finance Working Group's report that the financial condition of Massachusetts' hospitals, whose operating margins had been lower than national averages for many years, had deteriorated to among the worst in the country. At that time, the Finance Group believed there was reason to hope that the situation would improve without extraordinary state intervention, but recommended that the state increase its monitoring of hospital financial conditions.[18] By October of 2000, those conditions had deteriorated further and federal relief on Medicare rates had not been forthcoming. The Finance Working Group recommended that the state increase Medicaid rates and provide targeted assistance for particularly distressed hospitals. The state budget for fiscal year 2001 included both kinds of assistance. At that time, the state had commissioned a separate independent study of the adequacy of Medicaid payments to hospitals. That study, undertaken by The Lewin Group, was presented to the Task Force in September of 2001. The discussion of the Lewin Study and Medicaid hospital payment rates in the Finance Working Group is summarized below under the general intervention option of increasing state funding for hospitals.

As outlined above, since the Task Force's original discussion of hospital financial conditions, some hospitals – largely teaching hospitals – have improved their financial

[18] As noted above, the Commonwealth followed this recommendation by granting in the FY 2002 GAA specific authority to collect financial information more frequently.

condition, while others – largely, but not exclusively, community hospitals – have seen little improvement or further deterioration. (Figure 3)

1. Causes of Continued Financial Difficulty

Revenue Shifts and Low Payment Rates. Some of the causes of continued hospital financial distress were outlined above under "systemic problems." They include the combined effect of Medicare payment cuts resulting from the BBA, increased volume in low-paying managed care lines of business, decreased volume in well-paying indemnity lines of business, and Medicaid payments below cost and falling, in relation to costs.

Patient Volume Shifts. Another principal cause of continued financial distress among some hospitals is the effect of patient volume trends that show care shifting from lower-cost to higher-cost settings. Such a shift could cause problems both for the state and for the providers. Since Medicaid payments for many of the services used by Medicaid beneficiaries are related in some way to the cost of care in a particular site, the increased use of higher cost providers has generated higher overall Medicaid spending. For other services, Medicaid payments are based on average costs statewide, thus higher cost providers, such as t teaching hospitals, could be seeing increasing number of Medicaid patients but experiencing an increase in the gap between their costs and Medicaid revenue.

For some community hospitals, financial difficulty results from an inability to maintain a payer and patient mix that includes sufficient private payment and sufficient volume in well-paid courses of treatment to produce revenue that covers operating costs. The Finance Working Group examined Whidden Hospital as a case study in March of 2001, and found that significant volume, particularly among younger patients and patients covered by Medicaid and private insurance, had left the hospital. There remained principally an older population with diagnoses not well-reimbursed by Medicare, high emergency room volume and high bad debt. At the same time, teaching hospitals in the region experienced an increase in volume, including an increase in Medicaid volume. As a consequence, Whidden's financial distress was increased due to its loss of volume,

while the teaching hospitals increased their volume in Medicaid – reportedly a money-losing line of business, which would therefore increase Medicaid losses at those teaching hospitals.

Other community hospitals in regions northeast and southeast of Boston, which the Finance Working Group also examined, also lost younger patients with private insurance to Boston teaching hospitals, but to a lesser degree than Whidden. In other parts of the state, community hospitals in close proximity to teaching hospitals experience similar trends, sometimes for different reasons.[19]

The shift of patient volume away from community hospitals may be due in part to the loss of close ties between physicians and community hospitals – either because physicians that traditionally admitted patients to community hospitals have retired without replacements, or because physicians have realigned their practices after having their assets purchased by teaching hospitals, and/or because community hospitals have become less attractive to physicians and patients for other reasons. Most Finance Working Group members believe that most of the current number of community hospitals should be sustained because they are important to maintaining local access to important services, including emergency services, and because they offer a lower-cost alternative setting for many types of care than more expensive teaching hospitals. The Finance Working Group therefore recommended that the state conduct focused studies of the causes of community hospital distress and appropriate interventions.

Cost Increases. Hospitals have experienced very rapid increases in costs that are not recognized rapidly enough by most public as well as private payment systems. In particular, labor costs and supply costs have risen rapidly in recent years, but the inflation adjustment factors used by Medicaid and Medicare are at best a year or more behind these growth trends. The Medicaid inflation adjustment is discussed in more detail

[19] In 2001, Attorney General Tom Reilly issued a report on market conditions in greater Springfield, pursuant to a legislative directive (Section 93 of Chapter 236 of the Acts of 2000) that resulted from allegations that a community hospital had been inappropriately excluded from the network of one of the region's largest HMOs.

below. Rapid changes in the use of expensive technologies also pose problems for most formula-based payment systems. This problem is experienced by hospitals nationwide.

2. Options for Intervention.

Options for state intervention to alleviate hospital financial distress include increasing state funding for hospitals, forcing increases in private payments and preserving needed hospitals through rate regulation, increasing oversight and technical assistance through more detailed monitoring and identification of best practices, and intervention to alleviate detrimental effects of shifts in patient volume.

Increasing state funding for hospitals. The Finance Working Group supports increasing state funding for hospitals. It also recognizes that to do so thoughtfully, state leaders will need to address several complex questions about the state's role in financing private health care providers and the private health care system, and in providing access to necessary services for low-income people. Clearly the state has maintained and even expanded its role in paying for services for low-income residents through the Medicaid program. A number of years ago, the state decreased its role in regulating the health care system as a whole, and has instead relied on market forces to shape the development of the health care delivery system. Those forces have reduced excess capacity, but there is now concern that we may be on the verge of reducing the availability of some services to unacceptable levels and of taking out too many lower-cost providers – which could increase aggregate costs and lead to access problems. Should the state play a greater role to ensure system stability, and if so, how? In particular, should the state provide additional funding for hospitals? Questions such as these were posed, but not answered by the Working Groups.

Assuming that additional state funding would be available, there are several mechanisms through which additional funding for hospitals could be provided. In addition to increasing Medicaid rates for all hospitals, available mechanisms include relief through the Uncompensated Care Pool, and targeted funding for needed distressed providers.

Each mechanism would distribute funds in a different way and would benefit different hospitals. The most appropriate allocation of additional state dollars depends on the relative importance of several policy goals. The Finance Working Group suggests that following goals should guide decisions about where the state should concentrate increased funding:

- Fair Payment: Medicaid payment for a particular service should cover a reasonable percentage of the necessary cost of efficiently delivering that service.

- Medicaid Access Preservation: The state's Medicaid policy should work to ensure reasonable access to services for and by Medicaid enrollees.

- System Stability: The state should work to preserve and stabilize the health care delivery system in this time of financial difficulty. This goal does not mean preserving all existing hospitals and their service mixes, but instead means preserving a system that includes those hospitals and services necessary to protect the health of all Massachusetts residents. In light of the high number of hospital closures in recent years and current problems with emergency room overcrowding and ambulance diversion, the state should carefully assess the impact on access and system costs of the loss of any additional community hospitals.

There is considerable overlap between the Medicaid goals – fair payment and access preservation – and the broader state policy goal of system stability. This is especially true in light of the expansion of Medicaid eligibility that has led to Medicaid coverage of approximately 15% of the state's population. But there is unlikely to be uniformity in all three goals. For example, the state may have an interest in preserving certain lower-cost community hospitals for general public protection and public health reasons, even if they do not serve a substantial number of Medicaid and uninsured residents. In addition, raising Medicaid rates may not alleviate the financial condition of distressed hospitals. (Figure 20) Therefore, Medicaid rates are probably not the most efficient mechanism to use to further the goal of system stability – though the Finance Working Group has

recommended that rates need to be increased to further the goal of fair payment. The Finance Working Group has recommended that, in the short term, the state should balance additional state funding among Medicaid rate increases and targeted assistance to further the access and system stability goals. In the longer term, ideally, fair payment from all payers would be a key to maintaining access and system stability, and the need for other forms of relief would decrease. That notion is consistent with the view of most Finance Working Group members that Medicaid is not a grant program and that payment for services, in general, should support efficient providers (though the Finance Group also acknowledges that the Medicaid formula may appropriately include features that support hospitals with particular characteristics, such as disproportionate share hospitals and teaching hospitals). A useful approach would be to develop a multi-year plan that includes some yearly across-the-board Medicaid rate increases to make up for recent declines in the state's Medicaid payment-to-cost ratio, combined with limited extra Medicaid payments for other factors, and targeted distress relief funding emphasizing system stability and access preservation. Temporary relief from Uncompensated Care Pool assessment obligations is a mechanism to spread some amount of relief to all hospitals in this time of continued financial difficulty. An advantage of this multi-pronged approach is that it allows for immediate state intervention while also allowing additional time for further analysis of appropriate Medicaid payment policy and program changes.

Medicaid hospital payments. The Finance Working Group and the Task Force spent considerable time evaluating the Lewin Report on Medicaid hospital payment rates and the responses of the Division of Medical Assistance. A number of questions were raised in those evaluations that require further analysis and study. Nevertheless, the central finding of the Lewin Report – that Medicaid payments to hospitals are too low in relation to cost, given all other conditions in the system – rings true to most Finance Working Group members, and they recommend that the state provide some immediate increase in Medicaid rates to hospitals. Particularly troubling to the Finance Working Group is the use of an annual update or "inflation" factor that has been below actual inflation and that has resulted in increases in the gap between payments and costs since

1997 – precisely the period in which hospitals experienced Medicare payment cuts, decreasing private payment revenue, and increasing Medicaid enrollment. (Figure 22) The annual update factor is discussed more fully below.

Despite the important contributions made by the Lewin Study, questions remain that prevented the Finance Working Group from making more specific recommendations with respect to changes in the Medicaid payment formula. Instead, it recommended further study of hospital costs, cost allocation methods, efficiency, the share of costs of efficient hospitals covered by Medicaid, and the effect various changes to the payment formula would have on a hospital-by-hospital basis.

Further study of "efficiency" and its relationship to costs and payments is warranted. The Medicaid program is legally mandated "to ensure that rates of payment to providers do not exceed such rates as are necessary to meet only those costs which must be incurred by efficiently and economically operated providers in order to provide services of adequate quality." (This language appears in the annual state budget appropriation for the Division of Medical Assistance.) To comply with this mandate, Medicaid officials need to understand whether, and if so, why, the payment to cost ratio under Lewin's analysis may be high at hospitals deemed inefficient, or low at hospitals deemed efficient. Either result would prompt concern. In addition, Medicaid officials should consider what the relationship should be between efficiency and the Medicaid payment-to-cost ratio (e.g., should Medicaid cover a higher percentage of costs of efficient providers).

In addition, further study of hospital costs and the state's cost reporting system is recommended. The Lewin Report acknowledged that current cost reporting and cost allocation methodologies make it difficult to ascertain "Medicaid costs." The Lewin Group utilized a prevalent method of allocating costs across payers based on charges. With that calculation, it concluded that Medicaid paid hospitals 71% of their costs incurred in caring for Medicaid patients in fiscal year 2000. The ratio for inpatient care, at 81%, is much larger than that for outpatient care, at 58%, according to the Lewin

Study.[20] Although questions remain about whether the cost allocation method Lewin used is most appropriate for determining "Medicaid cost" in light of casemix variations, the Finance Working Group finds these low rates to be very troubling.

Thus, the Finance Working Group believes that the Medicaid rates should be increased and the state's payment to cost ratio should be improved to levels closer to what is paid in other comparable states. The Finance Group is not suggesting, however, that Medicaid pay even close to what hospitals estimate are their average costs of care. Hospitals and others have argued that each payer – Medicare, Medicaid, and each private payer – should pay its full "share" of hospital costs. But cost per case varies among hospitals considerably, and the cost-based reimbursement system this argument implies was abandoned in all states except one. Hospitals build their cost structures according to their best estimate of what the population in general will need and want, and in an effort to attract privately insured and privately paying patients. They also incur costs related to business plans that may not yield expected positive results (e.g., purchase of physician practice assets, discounted fees for managed care payers). Payers in the aggregate are then expected to provide whatever revenue is necessary to support those costs. Adopting a cost-based payment system, even if only for Medicaid, carries the risk of exacerbating health care cost inflation – which would be problematic for all stakeholders.

Medicaid payment for outpatient services raises a distinct set of problems and questions. Lewin demonstrated that Medicaid payments for these services were far below costs. In part, the Medicaid outpatient payment system is designed to encourage the provision of these services in lower-cost settings such as doctors' offices and health centers. This strategy is consistent with the legislative mandate to pay no more for services than the necessary costs incurred by an efficiently operated provider. If a lower cost provider could provide the service with quality and clinically appropriate care, it is at least questionable whether Medicaid should be required to pay hospitals a greater amount simply because their costs are greater for the same service.

[20] During fiscal year 2000, Medicaid covered 14% of hospital patients and contributed approximately 10% of hospital revenue statewide.

At the same time, however, the effect of this low payment rate has not been successful in redirecting patients to lower cost sites. Quite the opposite – more outpatient care is provided in teaching hospitals in Massachusetts than in almost all other states. Why? In some areas, lower cost settings are not available. In others, hospitals appear to have taken steps to steer patients away from other providers (for example, by purchasing community-based physician practices and/or employing community physicians directly). Ultimately, the responsibility for directing Medicaid patients to more cost-effective settings rests with the program and it should continue to aggressively pursue this agenda.

Options to address the outpatient problems include increasing payments for those services that must be provided in hospital outpatient departments from a clinical perspective and advising hospitals expressly that payment for other services will be based on the costs that an efficient provider of a lower-cost provider type would necessarily incur. In addition, care can be steered to lower-cost settings through case management or program rules. For these approaches to be successful, Medicaid payments for lower-cost providers should be adequate to support those providers.

For all services, Medicaid needs to establish a payment formula that works, in general application and over time, to establish a "fair payment" level, as defined above. The definition of "fair payment" will depend in part on the determination of "necessary" costs and efficiency, and also on the role of Medicaid within the larger system. For example, it may be acceptable for the Medicaid program to pay less than the full cost of care provided to Medicaid enrollees as long as Medicaid payments are above the added costs (marginal costs) of providing services to Medicaid enrollees. Such a strategy would require providers to receive higher payments from other sources, if their average costs are above these marginal costs. In the recent past, hospitals were willing to offer their services to other payers (certain private payers) at discounts from their average costs, resulting in significant losses for most institutions. The Finance Working Group expects that over time, this policy will be reversed.

With respect to both inpatient and outpatient services, the Finance Working Group believes that the Medicaid formula should include an update factor that appropriately reflects unavoidable increases in the necessary costs incurred by hospitals. The formula should also include a component that maintains an incentive for efficiency and good management. The current Medicaid cost adjustment factor recognizes general health care inflation using the federal "market basket" estimates, but limits recognition of labor cost increases to the optimistic projection of the anticipated increase in the consumer price index. (Figure 23) This has produced an annual increase in the Medicaid payment that has fallen further and further behind the costs incurred by Massachusetts hospitals. The Finance Working Group is troubled by this and by the fact that the hospital payment to cost ratio for Massachusetts Medicaid is among the lowest in the country. Therefore, the Finance Working Group recommends that the cost adjustment factor be re-examined and adjusted to be more consistent with actual inflation, and with the principles discussed below.

Ideally, an update factor formula would identify the actual unavoidable increases in costs necessarily incurred by efficient providers and would compensate hospitals for those increases; and it would separately identify those elements of overall hospital cost increases that could be lowered through management, and would discount those increases by some efficiency standard. Unfortunately, there is disagreement about whether such a separation of "unavoidable" and "manageable" elements of inflation is possible. One approach would be to attempt, through data collection and analysis, to separately identify the two types of cost increases and to recognize them in two different types of cost adjustment factors. Another approach would be to recognize the different character of cost increases through multiple components in a formula. For example, the Medicare update factor includes an inflation factor intended to reflect the amount inpatient costs are anticipated to rise overall, a productivity factor intended to reflect hospitals' ability to decrease costs by increasing efficiency, and a separate component to account for scientific and technological advancements. (Figures 24 and 25) Another example would be to derive an estimate of actual cost increases and apply a hospital-specific adjustment based on how efficient the hospital is compared with peer institutions in the state. In

other words, those hospitals judged to be efficient would receive an adjustment equal to actual inflation, while less efficient hospitals would receive a smaller increase. That approach would require a good measurement of efficiency at the outset. The Finance Working Group recommends that the Medicaid program consider these approaches and change its annual inflation adjustment factor to appropriately account for inflationary pressures not in the control of hospitals.

Uncompensated Care Pool Reform. The Uncompensated Care Pool is a second mechanism through which additional financial relief may be provided to hospitals. The Finance Working Group has recommended that a detailed evaluation of the Pool's funding and payment systems be undertaken, with attention to the effect that various changes would have on each hospital. The state budget for fiscal year 2002 includes a provision establishing a special commission on uncompensated care.

Distressed Hospital Funding. In the short term, grants to prevent certain distressed hospitals from closing or closing needed services may be required. The state budget for fiscal year 2002 includes such funding. Over the long term, systemic changes may alleviate the need for such targeted state funding. Some people argue that special relief for distressed hospitals and other providers counteracts the intended effects of market forces. However, those forces could lead to the loss of services needed to address the health care needs of the public. Such assistance can also prevent the loss of lower-cost providers that may, over the near term, regain market share as payment for services and distribution of care adjusts over the next several years. Some Finance Working Group members have suggested that the state should first identify which hospitals are needed and then should direct assistance to those hospitals, rather than creating a program for which all hospitals may apply (which some would say could lead to politically influenced decisions about which hospitals to assist). An alternative would be to make adjustments to reimbursement systems that would give lower-cost community hospitals access to additional payments similar to those currently benefiting teaching hospitals (graduate medical education payments) and safety net hospitals (disproportionate share payments).

In summary, the Finance Working Group recommends that Medicaid payments to hospitals should be increased as part of an overall relief plan. A component of this relief plan should focus on providing some extra funding for distressed hospitals that are judged to be important to maintaining adequate access to care for Medicaid enrollees and for other state population groups. The Lewin Study recommendations should be evaluated and the other questions pursued as more lasting changes to the Medicaid program and payment formulas, including the cost adjustment factor, are considered.

All-Payer Rate Regulation. Another option for intervention to stabilize hospitals is to pursue rate regulation as a means of guaranteeing adequate payment from private payers as well as Medicaid. This system would offer the advantage of virtually guaranteeing survival of distressed hospitals, at least in the short term. It would also require treating all hospitals alike under the formulas used – which would prevent targeting and also eliminate the potential for politicization of distribution of distressed hospital funds. Longer term, however, it could artificially prolong the existence of hospitals that might not be needed for access purposes, and it could contribute to system cost increases. Also, it would require enhanced cost reporting and analysis and increased health planning. For example, the state would have to determine the appropriate method for counting beds (licensed beds vs. staffed beds, for example) and the appropriate number of beds to maintain through a rate-regulated system. These questions are difficult to answer, but some members of the Finance Working Group believe that the state should move in this direction. A significant obstacle to this approach is the fact that the federal government is unlikely to agree to allow Medicare to be subject to a new state all-payer system. Without Medicare participation, the effects of rate regulation would be much more difficult to predict.

Increased Oversight, Monitoring and Technical Assistance. The Finance Working Group has recommended that the state increase financial reporting by health care providers and that the state increase its analysis and monitoring of the system. There is disagreement about whether the results of those analyses should be published or should be kept

confidential by state officials. Some people argue that reporting individual hospitals' results could precipitate the demise of a hospital found to be in financial peril. Others point out that financial difficulty is generally not secret for long, and that increased transparency of information, similar to that required of publicly-traded companies, will lead to better management and, where appropriate, earlier public intervention. In addition, the state could identify best practices in hospital management and could assist hospitals in implementing them. A provision in the current state budget directs the Division of Health Care Finance and Policy to publish an annual report identifying hospitals it believes to be in particular distress. The state's experience with this new requirement will inform further policy development in this area.

Intervention to Alleviate Patient Volume Shifts. As outlined above under "system problems," the state could intervene to help alleviate shifts in patient volume toward higher cost providers. Particularly with respect to Medicaid enrollees, alleviating this shift could have positive effects on the financial condition of both the higher cost and lower cost providers. Of course, care could only be shifted where clinically appropriate and high quality care is available lower cost settings. Arguing against this type of intervention is the notion that markets in which hospitals compete for patients are expected to produce winners and losers, and the "chips" should fall as they may. In addition, efforts to shift patient volume run counter to the principle that patient should be able to choose their provider. One way to pursue this option without directly restricting patient choice would be to forge a partnership between hospitals and the Medicaid program focused on encouraging clients to choose lower-cost clinically appropriate settings and providers.

B. Nursing Homes

Financial conditions in the nursing home sector are serious. Even though there is reason to hope that conditions are beginning to improve for some facilities (Figures 26 and 27), conditions overall remain financially weak. Nursing homes have continued to close, and more are at risk of closure (Figures 28 and 29). Although access to nursing home care

appears to be adequate in most areas, occupancy rates in some regions are as high as 97%, and further closures in those areas could lead to access problems. Industry representatives predict that if closure trends continue, there will be no more available beds by January 1, 2003. Facilities in financial trouble may have even more difficulty than others in attracting and retaining staff, leading to the potential for problems in quality of care. Complaints about nursing care in nursing homes have been on the increase and are a cause for concern. (Figure 30)

Several factors contribute substantially to financial distress:

- Nationally and in Massachusetts, many nursing homes were purchased in the 1990s by national or regional chains that borrowed heavily to finance their acquisitions, leaving those nursing homes with increased debt service and revenue requirements.
- The BBA significantly reduced Medicare payments to nursing facilities. Despite federal "give-back" legislation, Medicare revenue remains substantially below pre-BBA projections. (Figure 31)
- Massachusetts nursing homes rely on Medicaid to pay for a higher percentage of their residents than is average for the industry nationally. Medicaid rates are not designed to yield a cushion to subsidize significant changes in conditions and may be lower than the cost a given facility incurs in providing care. With relatively few privately paying residents, Massachusetts nursing homes have little access to non-Medicaid funding.
- Many nursing homes, like other providers, report extreme difficulty in attracting and retaining qualified direct care staff.

Other factors affect particular nursing homes, exacerbating what are generally bad conditions in the industry. Low occupancy is the strongest predictor of low total profit margins. Other significant predictive factors include high nursing expenses and high administrative expenses per day, low patient acuity levels, and high percentages of Medicaid-covered residents.

The Finance Working Group is concerned that quality of care may deteriorate due to financial pressures and difficulty in attracting and retaining staff, and that access may become a problem in some areas if many more nursing homes close in the near future. Some of the forces contributing to nursing homes' financial difficulties, such as Medicare payment rates and worker shortages, are beyond the state's immediate control. Because Medicaid pays for such a high percentage of nursing home residents' care, Medicaid must play a dominant role in resolving what appears to be an unstable situation.

Options

As discussed more fully below, the Commonwealth's planning and policy development around long-term care should decrease dependence on facility-based care and expand community-based options, over the long term. The principal tools the state has to improve the situation of nursing homes in the more near term are state funds (through the Medicaid rate, special loans or grants), technical assistance, and state regulatory policy. Because of the high degree to which nursing homes depend on Medicaid, and the degree to which Medicaid relies on nursing homes to care for its enrollees, the state bears a special responsibility to engage and work with the nursing homes to avoid serious access and quality problems and to restore financial stability to the sector.

Medicaid payments. The state Medicaid program has been moving toward a standard Medicaid rate system based on statewide average recognized costs rather than on facility-specific reported costs. This is generally a sound pricing approach, provided that standard prices are set at a level that is high enough to provide revenue sufficient to maintain an efficient, well-run facility that provides safe, adequate and dignified care for Medicaid patients. Medicaid should not pay for additional costs that some facilities may have incurred investing in more expensive services used primarily by Medicare patients (who generally require more intensive care) or higher-end amenities to attract privately paying residents. Certain adjustments to standard rates for regional variations in cost and conditions may be appropriate. Substantial Medicaid rate increases across the board or increases that raise rates disproportionately for high-cost facilities would fail to recognize

important variations in efficiency, cost and quality, and could even reward bad management practices and fail to reward good ones; therefore the Finance Working Group recommended against this type of increase.

Despite the fundamental soundness of the standard pricing approach, certain features of the rate-setting method and of the method being used to transition from facility-specific, cost-based rates to the standard rates should be re-examined: the minimum occupancy threshold, the ceiling on "total payment adjustment," the relationship of the base year of costs recognized and the adjustment from base year to rate year.[21] The Finance Working Group discussed these recommendations in June of 2001, and understands that rates proposed for the period January 1, 2002 through June 30, 2002 include a substantial increase in the "total payment adjustment" ceiling, but do not account for the remaining recommendations. The Division of Medical Assistance and the Division of Health Care Finance and Policy have committed to updating the base year of recognized costs for rates as of July 1, 2002. The Finance Working Group recommends re-evaluating the occupancy threshold and the adjustment from base year to rate year, and adjusting them as appropriate.

A more comprehensive approach to the Medicaid rate issue would be to contract for a study of the rate-setting method to determine whether the standard rates it yields are adequate to cover necessary costs, and whether the rate-setting formula can include incentives for high quality care and efficiency.

Targeted Financial Assistance. In the short term, special assistance for particular facilities may be necessary to preserve efficient and high-quality facilities. In the long term, appropriate rate-setting methods should produce Medicaid payments sufficient to sustain these providers.

[21] These features are discussed in greater detail in the June 25, 2001 Finance Working Group report to the Task Force (Attachment __). Briefly, the occupancy threshold merits re-examination in response to industry representatives' claims that due to increased patient acuity and decreased lengths of stay, more flexibility is required than was the case when the threshold was set; most nursing homes are not able to meet threshold. The update factor merits re-examination for the reasons discussed under the heading

Increase Private Resources. Although there is disagreement on whether the expansion of private resources in the long-term care sector is likely to succeed, some members of the Finance Working Group believe it is important to explore. For example, if family members were permitted to supplement Medicaid payments to obtain certain amenities for a nursing home resident, the facility would have access to additional revenue. Disadvantages include that such a system could lead facilities to discriminate against residents whose families do not have access to such additional private resources.

Increase Coordinated Monitoring and Policymaking. The Commonwealth should increase and coordinate regular monitoring of nursing home financial conditions (e.g., by requiring submission of audited financial statements), occupancy rates and bed availability, and availability of alternative care services by region. Agencies that regulate various aspects of the nursing home industry should work more closely together to coordinate policy. For example, capital improvements required by the Department of Public Health for quality of care purposes should be coordinated with capital financing and reimbursement available through Medicaid or other sources. Where monitoring shows that access has become problematic in a particular region, existing restrictions on new beds may need to be lifted, or special program created to facilitate access to needed services. Bankruptcy should trigger heightened monitoring of quality of care.

Provide Technical Assistance. Identify best practices of efficient, low-cost and high-quality facilities.

Continue workforce initiatives. The Commonwealth's workforce initiatives aimed at developing career ladders and wage pass-through funding for direct care workers should be continued, at least in the near term. Additional measures that might ease the workforce pressure include adjustments to licensure and professional practice restrictions.

"Hospitals." The ceiling on total payment adjustment merits re-examination because it adversely affects efficient and historically low-cost providers – precisely those the state should try to preserve.

Long Term Planning

Over the longer term, long-term care planning should focus on developing a cost-effective and high-quality community-based continuum of care. A major challenge in this effort will be determining how to develop that continuum of care in light of limitations on available public resources, particularly while nursing home residents continue to rely on facilities for their care. There is no current capacity to transfer residents of facilities to the community on a large scale, and there will always be some people who require facility-based care. This problem is not new, and it may be particularly challenging for Massachusetts in light of our high utilization of nursing facilities. The Vision 2020 Commission[22] is charged with addressing this and related challenges. In the near term, state policymakers should do what they can to support community-based providers while maintaining necessary nursing facilities. In the longer term, it will be essential to identify and support more innovative and promising methods of organizing and providing long-term care.

C. Community-based Providers

Data on the financial conditions, efficiency and effectiveness of many community-based providers are not readily or consistently available. The lack of consistent and good data inhibits thoughtful state policy and should be corrected through better reporting and monitoring mechanisms. According to reports from provider representatives and the data that is available, financial conditions among community-based providers are generally tenuous.

1. Community Health Centers

There are 47 Community Health Centers (CHCs) that provide services at 100 practice sites in Massachusetts. 37 are independently licensed and 17 operate under hospital license. Twenty-seven, located in designated medically underserved areas, receive direct

federal funding. Data presented by the Massachusetts League of Community Health Centers (the League) suggest that on average, 75% of CHC operations are supported with public funding. Sources include Medicaid, the Uncompensated Care Pool, and grants from federal, state and local sources. CHCs are growing and serving increasing numbers of people. According to a report issued by the Division of Health Care Finance and Policy, CHC visits increased by 93% over the last 9 years.[23]

According to the League, a majority of CHCs lost money on operations between 1995 and 1998, and even more did so in 1999. During the same time, 60% of CHCs maintained less than 30 days cash on hand. In addition, salaries at CHCs are well below market. Increasing patient volume and difficulty finding and retaining staff – particularly nurses and dentists – means waiting times are long and growing longer. Despite these difficulties, CHC patient satisfaction remains high. Patients appreciate the patient-centered approach and cultural competence most CHCs offer.

The Finance Working Group believes that the state should explore whether CHCs can offer a lower-cost alternative setting for some of the care now being provided in hospital outpatient departments and emergency departments. Though it is not clear from data available and the Finance Group's discussions with CHC representatives whether CHC services would end up costing less than current rates paid for hospital outpatient services, it seems likely that their costs would be lower and care, particularly for low-income and language-minority patients, might even be more satisfactory. The Finance Working Group has recommended that the state continue to invest in CHCs and explore the role CHCs can play in redirecting care towards appropriate lower-cost settings.

Among the recommendations offered by the League, which the Finance Group believes are worth exploring, subject to availability of resources, are the following:

- Review Medicaid rates and other public payments (e.g., from the Department of Public Health) for appropriateness.

[22] This group was created in line item 9110-0100 in the fiscal year 2002 state budget (Chapter 177 of the Acts of 2001).
[23] DHCFP, Massachusetts Health Care Trends: 1990-1999. October 2000.

- Lessen administrative costs by reducing rigid contract requirements, coordinating state billing and reporting requirements across agencies.
- Help improve relationships between CHCs and their local hospitals to facilitate movement of care to lower cost appropriate settings.
- Create a State Health Service Corps to help CHCs attract and retain quality staff (including tuition assistance and loan repayment opportunities).
- Provide resources for technical assistance and upgrading of CHC systems.
- Provide grants for urgent needs, deficits and expansion.
- Provide low-interest loans for service expansion.

2. Home Health Care and Other Community-based Providers

Home health care providers report that in the aggregate, their revenue falls short of their costs by approximately $20-25 million. Medicare, which covers 50-60% of home health patients according to industry representatives, declined drastically as a result of the BBA. On a positive note, industry representatives report that home health care providers' experience under the new Medicare prospective payment system is generally positive, and Medicare revenues are now covering costs. Home health care providers are concerned, however, that Medicare payments are scheduled to be cut by 15% in the near future.

The pediatric home health care system is under particular stress. According to industry representatives, many of the hours of care prescribed by physicians go unfilled due to staffing shortages, which are related to low reimbursements and the lack of adequate payments for overtime. Since the Task Force discussions on this issue, some children in need of such services have sued the state, claiming that Medicaid rates are too low to allow adequate access to services.

In addition, chronic underfunding has left home health care providers undercapitalized and unable to invest in technology that could increase their administrative efficiency and telemedicine equipment that could increase the productivity and effectiveness of clinical

personnel. These investments are particularly important as home health care is subject to large amounts of paperwork requirements and, like other providers, is experiencing staffing shortages.

Other community-based providers, such as adult day health providers, assisted living providers, and home care programs working with the Executive Office of Elder Affairs point to financial difficulty and problems in obtaining funding for clients who need their services and who do not have adequate private resources. Their problems appear to result from the combination of limited funding streams available and complicated and restrictive eligibility rules for those funding sources that exist. Ironically, it appears to be easier for some people, particularly those who require skilled care, to obtain Medicaid funding for facility-based care than to obtain home health and home care services that would allow them to remain in the community.

Causes and Interventions

Medicaid rates and service eligibility rules. Community-based providers believe that low Medicaid rates and, for some, restrictive service eligibility rules contribute to their financial stress. Medicaid, like Medicare, restricts eligibility for some services, such as home care, to those with the most intensive service needs. Broadening eligibility would increase program costs and could draw into the program people who are currently receiving services they need from family members or other informal supports – which might help many people and providers, but would also involve considerable expansion of the Medicaid program. This seems unlikely in the current fiscal climate. Nevertheless, Medicaid rates and service eligibility rules should be reviewed as part of an intensive long-term care planning effort. Policies should be focused on encouraging use of the most cost-efficient, community-based care services appropriate to clinical needs.

Alternative Reimbursement Systems for High-Volume Providers. For providers that serve an especially high percentage of Medicaid clients, the state should explore special

contractual relationships that allow for alternative reimbursement systems, such as a prospective payment system similar to the new Medicare system.

Grant programs for particular capital needs. The state should explore whether providing grants or low-interest loans to community based providers for specific capital needs would increase the efficiency and effectiveness of those providers. The prime example of an area worth exploring is whether the state should assist home health providers in acquiring telemedicine technology. For a minimal amount of money, which would be difficult for these providers to access, great efficiencies could be gained.

Pilot Programs. The state should explore different models of community-based care through pilot programs and demonstration projects. It is likely that different models will be developed that address community needs better in one area than in another. Funding limited programs on a trial basis will help determine which policies work best and will help develop an infrastructure that allows for flexibility.

Coordinate Services and Eligibility Rules. Within the limits of federal law, and state-funded and administered programs should be coordinated so that eligibility rules and funding streams do not create barriers to service plans that are the most efficient and lower-cost way of meeting people's needs.

D. Physicians

Physician practice conditions and incomes in Massachusetts are said to have deteriorated over the last several years primarily due to changes in the nature of physician practices and lack of adequate payment.[24] Despite the increasing amounts of time that physicians must spend on paperwork, returning patient phone calls, research and patient management, most payment systems still rely on the number of patient encounters as the method for determining physician productivity and sometimes, payment. The benefits that physicians sought in joining larger integrated systems of care – including efficiency

[24] Due to the lack of hard data on many aspects of physicians' quality of life, the Finance Working Group has relied on physician representatives' descriptions of trends.

and economies of scale in administrative matters and overhead as well as increased bargaining power with managed care companies – seem not to have materialized in a way that has made physicians' professional lives sufficiently more rewarding or simpler than they were in solo or small group practices.

In addition, payment rates from Medicare, Medicaid and private payers have failed to increase as rapidly as practice costs. Physician income in Massachusetts continues to be lower than in many other parts of the country. Anecdotal evidence abounds that physicians are working harder and harder to support the same level of income. Recruitment and retention of physicians in Massachusetts has become problematic.

Notwithstanding these increasing difficulties, Massachusetts continues to have more physicians per 100,000 population than any other state and more than the national average. (Figure 7) These numbers may not reflect physician availability, as many physicians divide their professional effort among patient care, research, and teaching. On the other hand, the many interns and residents in Massachusetts provide large amounts of patient care at teaching hospitals, often working extraordinarily heavy schedules. Overall, the supply of physicians is generally adequate. Certain specialties, such as anesthesiology, radiology, dermatology, and child and adolescent psychiatry, and certain geographical areas are experiencing shortages. There is some risk that Massachusetts may lose its preeminence in the medical field if deterioration in practice conditions and reimbursement persist.

<u>Options</u>

- Medicaid rate increases would help alleviate the physician reimbursement problem. As funding is scarce, rate increases could be targeted at services that are most important to Medicaid enrollees (e.g., primary care) and most cost-effective (e.g., community based physicians, as opposed to hospital-based physicians). It may be appropriate to compensate differentially those physicians whose practice has a significant percentage of Medicaid enrollees. With respect to so-called

Medicare crossover claims,[25] it is not clear that the Medicaid program should assume the full cost of Medicare allowable fees, particularly in a time of tight financial resources. Ideally, physicians should be able to obtain any difference between the Medicaid payment and the Medicare allowable fee from the federal government.

- The state should also collaborate with physicians to achieve administrative simplification through HIPAA compliance and in the Medicaid program in general.
- New capitation models should be explored, but must include sufficient payment rates and adequate data to support quality and effective management of care.
- As with other sectors, data about physician practice, costs and practice patterns should be collected and monitored.

E. Workforce

Dr. Roderick King, Director of the Boston Regional Office of the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services, and Louis Freedman, Commissioner of the Division of Health Care Finance and Policy, addressed the Task Force about workforce issues in March, 2001. Workforce shortages are creating problems in health care across the country, particularly with respect to nurses, direct care aides and pharmacists.[26] The problem is related to low supply, and also to distribution of workers. The shortage affects wage costs and, therefore, costs of care. In addition, diversity of the health care workforce is frequently mis-matched to the population served.

[25] The term "Medicare cross-over claims" refers to the patient-responsible amount for patients who are eligible for both Medicare and Medicaid. Because the two programs have different fee schedules, the question arises whether Medicaid, which pays for the patient-responsible amount, should use its own fee schedule in determining the amount to pay (as it does for other Medicaid enrollees who have access to other insurance) or whether it should use the Medicare fee schedule in determining the amount it will pay. The issue is illustrated in Figure __.

[26] It is unclear whether the current economic slow-down will have a positive effect on the health care workforce shortage. The state and federal government should monitor the situation and try to create opportunities for people who become unemployed to ease the worker shortage in health care.

Massachusetts has more hospital employees per 1000 population than any other state in the country. Yet most hospitals and virtually all other health care providers in Massachusetts report that attracting and retaining nurses and other direct care workers is among their most significant and challenging problems. The average age of nurses is increasing, and demand for their services far outstrips the supply of nurses in practice and in training.

A variety of factors influence the problem. Working conditions for nurses are making the profession less and less attractive; alternative positions for nurses that draw on their clinical skills but are outside the field of direct care, such as utilization review and quality inspection, are attracting some away from patient care; increased opportunities for women may decrease the number who enter nursing, and the return on the investment of time and money in education may be higher in other fields.

Options for state intervention take three main forms:

Education strategies. These can be focused on financial support and incentives, such as scholarships and loan repayment programs, or on designing new training programs. The latter can take months and sometimes years.

Job-related strategies. These efforts would focus on re-designing nursing and other direct care jobs to make them more attractive; improving working conditions generally; and building career ladders so that more direct-care jobs would lead to a professional development path.

Influencing demand. This type of intervention would involve changing the scope of practice of some kinds of workers so that tasks could be re-assigned, and in some cases the number of one type of professional as opposed to another could be reduced. This strategy would have to be closely tied to quality initiatives, to ensure no adverse results from re-assigning duties.

Resolution of workforce issues requires solutions that reach beyond the health care sector to involve the academic community, labor unions, and public schools. The Commonwealth has enacted a number of programs designed to improve the workforce problem, including a wage pass-through program for certified nursing assistants working in nursing homes and career ladder programs for certified nursing assistants.[27] Proposals for scholarship and loan repayment programs have been put forward, but have not been enacted. The level of priority assigned to this problem in the current recession, and the question whether the recession has had an easing effect on the health care worker shortage, remain to be answered.

F. Prescription Drugs

The phenomenon of skyrocketing prescription drug costs in the United States has been well documented and widely reported. Some of the main features of the phenomenon include:

- The high cost and high utilization of new drugs are more significant factors than increases in prices for existing drugs. (Figure 9)
- The benefits of some new drugs over previously available therapies are hard to quantify.
- Utilization of new, high-cost drugs is encouraged by direct-to-consumer advertising, on which drug manufacturers spend increasing amounts of money. (Figure 32)
- Access to affordable drug coverage is particularly problematic for seniors, as Medicare continues to lack prescription drug coverage and many employers are cutting back on retiree health coverage. (Figure 33)

The November 19, 2001 Finance Working Group report outlines current state strategies for increasing access to prescription drugs and controlling cost increases.

[27] The FY 2001 GAA included [summary]; the FY 2002 GAA includes [_].

Options for more aggressive state action in the prescription drug arena include mandatory price controls, and establishing the state as a wholesale purchaser of drugs for all residents and health plans. The state could also explore the possibility of establishing a single-payer type of insurance plan for prescription drugs, in which participation by health plans would be required. Although ultimately, intervention from the federal government will probably be required to achieve significant savings on prescription drugs, exploring alternative state plans is recommended.

G. HMOs/Insurers/Payers

The Task Force's analysis of financial conditions in the private insurance market focused on the state's four largest health maintenance organizations, which cover the largest portion of residents who are covered by state-regulated insurance. Many residents are covered by self-insured employer plans governed by the federal government pursuant to ERISA.

Four major concerns guided the Finance Group's discussion: (1) the need for enhanced HMO financial strength, through increased reserves and positive operating results; (2) discomfort with the disparity between premiums paid by small groups and individual enrollees and premiums paid by large groups; (3) a belief that premiums in general should be "affordable"; and (4) a belief that payments to providers should be timely and adequate. The Finance Group acknowledged that these general concerns are in tension with one another and that too much emphasis on any one of them could exacerbate problems involving one or more of the others. For example, while premium increases appear to be necessary to improve health plan solvency and to pay for the rising cost of care, those increases may also increase the number of people without health insurance. Health plans are at the center of many pressures exerted by stakeholders in the health care system: employers and other payers want to keep premiums affordable, providers need adequate payment, and consumers want access to services and providers at low or no additional cost.

More specific problems are outlined in the Finance Working Group's report on this issue. The Finance Working Group recommended, in general, that the state pursue the following strategies:

- Enact legislation establishing minimum net worth and risk-based capital requirements consistent with national standards
- Require that plans report financial results by line of business, that they file reports using statutory accounting rules as well as Generally Accepted Accounting Principles, and that they report on ASO (Administrative Services Only) business and enrollment.
- Explore approaches to increasing oversight of risk-sharing arrangements and risk-assuming providers to ensure that providers have the operational capability and the financial resources to manage the risk assumed and that the financial terms of the arrangement are reasonable.
- Consider new mandates, including mandated benefits and reporting requirements, in relation to any premium increases they will require.
- Enact legislation giving the Commissioner of Insurance authority to oversee certain major transactions of HMOs, such as sales of substantial assets, mergers, and expansion into other states.
- Explore the possibility of requiring that premiums be certified as actuarially sound by an independent analyst.

Since the Task Force discussed this issue, the financial condition of our largest HMOs has improved. Although there has been no new legislation in response to these recommendations, the Finance Working Group believes that there is continued need for increased oversight of and authority over health plans in Massachusetts.

H. Employers

After several years of little or no increase in health care coverage costs in the mid-1990s, employers have experienced several years of significant increases in premium costs

(Figure 5). While the economy flourished and employee retention was an important goal, many employers did not pass on much of the annual premium increases to their employees. In a strained economy with diminished corporate profits, this approach is unlikely to be sustained. The main challenge employers are focusing on is controlling the rate of increase in health care costs.

As costs have begun to increase rapidly again in the post-managed care backlash era, employers have re-engaged in the search for ways to improve the efficiency and effectiveness of the health care system. Some strategies involve employers' assuming more control over plan and provider network design. Most include increasing consumer responsibility for and control over care decisions and costs, and aligning incentives for physicians to direct care to the most efficient providers and to weed out unnecessary care. The main tool supporting these strategies is information – about quality, cost and efficiency of different providers and different treatment options. Information is being coupled with financial incentives for consumers and providers. In addition, employers are exploring lower-cost self-insured alternatives to commercially available managed care and insurance products, and are developing strategies for incenting providers to use resources more efficiently and to reduce medical errors. More detail on the options being pursued is available in the November 19, 2001 Finance Working Group report.

I. Consumers

Many employers and others believe that consumers must be engaged more actively in the effort to reduce overall health care costs and cost increases. Trends show that consumers have been choosing more expensive providers and prescription drugs. Yet most people are unhappy with the high cost of health care coverage – which is driven in part by their choice of provider and treatment.

Some members of the Finance Working Group do not believe that consumer incentives are likely to affect choice of provider, because most people choose the provider their physician suggests. Other Finance Working Group members are optimistic that a

combination of consumer financial incentive, physician financial incentive, and intensive education of both consumers and providers about relative cost and quality of providers will lead to changes in patients' choice of provider and will slow the rate of health care cost increases. Decisions about appropriate policy changes will have to be made based on an assessment of who is really driving provider choice. In either case, however, more reported information about provider quality, cost and efficiency would help patients and physicians make decisions. Reporting efforts based on this principle should be supported.

IV. The Future of Health Care Policy Analysis in the Commonwealth

A. Reflections on the Task Force Process

The Task Force, through its working groups, succeeded in finding facts and identifying forces and trends affecting the Massachusetts health care system and its financial stability. One of the most important functions of the Task Force has been to provide thorough background and understanding of the health care system to the state leaders who convened it. The combination of analysis and reports by the working groups and invited guests along with discussion and commentary by thoughtful participants and stakeholders in the health care system performed this function well.

The Task Force did not find or recommend comprehensive solutions to the problems of high aggregate cost, provider financial performance disparities and the appropriate structure of regulatory oversight and state intervention. It also did not provide firm recommendations in a number of areas. These outcomes, disappointing to some, are to be expected in light of the complexity of the system and the lack of agreement that comprehensive system reform is needed. In addition, the members of the Task Force who are direct stakeholders in the system understandably view proposed solutions from their own interested perspectives. Therefore, the solution most Task Force members could agree on most readily was that more money from the state would help. On more challenging questions such as achieving administrative simplification through adopting

some common type of information system – which would inevitably cost some participants more than others – agreement could not be reached.

In addition, the Task Force has not addressed all the items listed on the topical agenda for 2001 in the Task Force Interim Report. Available time and resources limited our inquiry. These items still merit detailed consideration:

- The Uncompensated Care Pool (soon to be addressed by a Special Commission on Uncompensated Care, pursuant to section 74 of Chapter 177 of the Acts of 2001).
- The role of health care in the Massachusetts economy (together with projections of the effects various interventions, and failure to intervene, may have on the economy).
- Access to health services by region.
- Mental health, which the Finance Working Group strongly recommends be assigned to a separate focused working group.
- Dental care.
- The role of the determination of need program.

The Interim Report also highlighted the need to discuss several questions, the answers to which may change over time. Those questions, and several points that may be useful in considering what the answers may be, are as follows:

1. What is the appropriate role of competition among providers and insurers? Does Massachusetts have enough providers and insurers to enable competition to play and effective role? Should providers or insurers be maintained for competitive reasons, even if that requires intervention with taxpayer dollars?

2. What is the appropriate role of state health planning? Should the state determine which facilities are needed to preserve access to health services? If so, what agency,

person, or group should be the decisionmaker? How would decisions about whether a particular provider is "needed" be implemented?

3. How much is too much to spend on health care in Massachusetts? At what point will our health care costs dissuade businesses from locating here?

In some ways, the last question should be answered first, because it sets the limits within which the state must set health care priorities. Of course, there is no specific threshold at which businesses will choose to locate elsewhere or will relocate outside Massachusetts based on health care costs, but trends in this area should be monitored. Employers are already exploring lower-cost alternatives to commercially available insurance plans. Some have relocated portions of their operations to other settings. The degree to which health care costs have influenced those decisions is not clear, but the state should investigate the question.

Even if employers do not relocate, it is reasonable to expect that they will shift more health care costs to employees as those costs continue to increase – particularly while corporate earnings are low. Some will drop coverage altogether. It is reasonable to anticipate that rates of uninsurance will rise. There is a threshold at which the cost of health care coverage will place it beyond the reach of too many Massachusetts residents. The effects of that situation on providers, on the health status of residents, and on the state's attractiveness as a business location, and on the political viability of major health care reform are not yet clear, but they are likely to become more clear unless strategies for constraining cost growth can be implemented.

The first and second questions outlined above relate to one another and will affect state leaders' analysis of the appropriate actions to take with respect to the health care system. Competition plays an important role in encouraging efficiency, but it may also be related to the shift in patient volume towards teaching hospitals. For example, teaching hospitals purchased community physician practices in part to position themselves to compete for global managed care contracts. The resulting change in physician alignment and practice

patterns is likely a force in the shift of inpatient volume away from community hospitals. That trend is driving up system costs and contributing to premium increases. In turn, those increases are likely to lead to increases in uninsurance. There may be instances where providers or insurers that are faltering should be maintained, even if requiring the use of public funds, for a period of time to determine whether they can be restored to stability or whether the system can adjust to their absence without an unacceptable loss of access to services. A remaining challenge is to find ways of instilling in each market participant an incentive to improve efficiency of the system overall.

There is an increased role for state involvement in health care, at least with respect to data collection and monitoring of financial conditions and access. There is disagreement on whether the state can and should determine which facilities are "needed" and which are not. State agencies are already coordinating more than in past years, and they will need to continue to work together to determine appropriate interventions when providers threaten to close or terminate essential health services.

B. Recommendations for the Future

The Finance Working Group had several advantages: its topic was based on data and analysis, even if subject to variable interpretation; its members were not directly representing providers and insurers whose financial distress led to the creation of the Task Force and the Working Groups; and it included a cross-section of academics, former regulators, and consultants who were familiar with a variety of aspects of the health care system.

The Finance Working Group has suggested several versions of an ongoing analytical group to assist state policy makers in the executive and legislative branches. To add slightly more detail to that recommendation, the Finance Working Group suggests that such a group should have the following features:

Mission: To educate leaders and the public about trends and conditions in the health care system; to perform and report analysis that sheds more light on the conditions of and trends in the health care system.

Function: To mediate (i.e., to facilitate communication of data, interpretation and views on issues) between and among government, the public, and the health care delivery and financing systems; to understand, communicate, and go beyond the vested interests and views of system participants to advise government on the system as a whole.

Authority: Advisory only, not regulatory authority. The group should, however, have a specific audience and expected reporting venues, such as hearings or public meetings of a larger more formal group.

Mandate:

- To report on conditions and trends in the health care system based on data collected by government or publicly available;
- To report periodically on a small number of predictable issues – for example, reviewing the Medicaid annual update factor, regular review of levels of uninsurance in Massachusetts, and other specific metrics defined by state leaders.
- To comment on particular issues as requested by the Governor or Legislature;
- To monitor, analyze and report on linkages and connections between parts of the health care system – especially those that may not be monitored and reported on by a particular constituency (e.g., monitor nursing home bed closures and occupancy rates, determine whether they correlate with numbers of hospital inpatients awaiting nursing home placement and high hospital occupancy rates).
- To present reports according to a set schedule to a larger health care forum including political leadership, health agency commissioners and observers (including legislative health care committee staff).

Membership:

- Ten to fifteen people with health care experience and expertise; include a minority of state agency representatives (e.g., Attorney General's Office, Division of Health Care Finance and Policy, Division of Medical Assistance, Department of Public Health).
- No private sector members currently serving in or representing providers or insurers; direct stakeholders should be represented in a larger discussion forum that responds to the smaller analytical group.

Duration: should be time-limited, but not too short to allow for continuous monitoring of trends. The Finance Group suggests five years, subject to renewal.

Audience: A health care forum similar to the Task Force (including political leadership, high-level officials and private sector stakeholder representatives), though a smaller group might allow for easier discussion and interaction; the forum would meet approximately quarterly to hear and discuss reports from the analytical group.

Models from other states, the federal Medicare Payment Advisory Commission, and past experiences in Massachusetts (e.g., the Hospital Payment Advisory Commission, which existed in the mid-1990s) should be reviewed for helpful lessons. When examining models that have not worked particularly well, state leaders should assess whether current conditions differ from those that prevailed at the time or place in question, and whether changing certain features might lead to a more constructive model.

The Finance Working Group continues to believe that such an ongoing public-private analytic effort would be useful at this time as the state re-assesses its role with respect to regulation of and intervention in the private health care system and protection of the health care safety net. The Working Groups and the Task Force have served an educational purpose and provided a forum for communication about the health care system. Continued analysis and communication between public and private stakeholders will be essential as conditions continue to present challenges to public and private leaders in health care. An ongoing group whose mission transcends that of any existing agency

in health care and whose members include people from the private sector would provide a structure and framework for that continued analysis and communication.

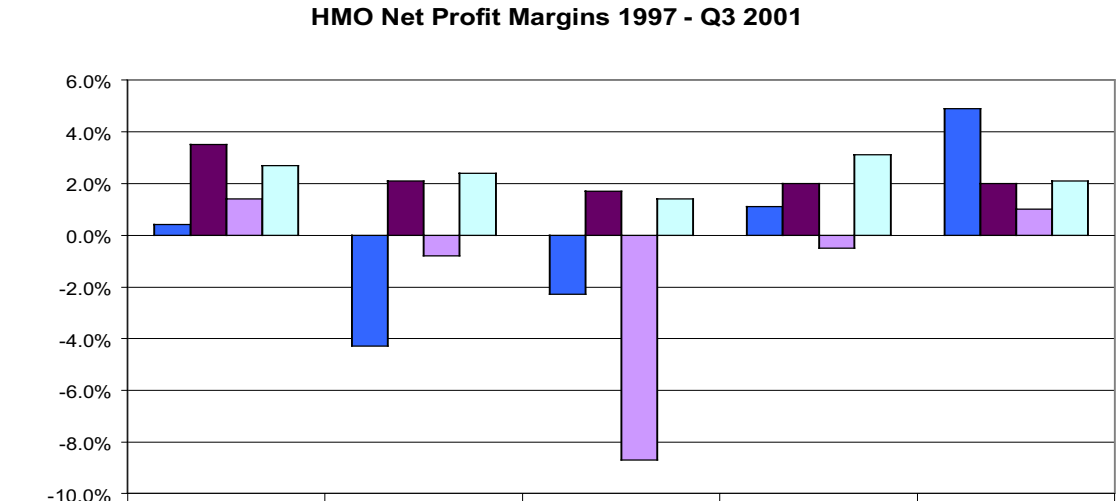
FIGURE 1:

1999 Ratio of Hospital Payment to Cost by Payer and State

	Medicare	Medicaid	Private Payer
US	**1.02**	**0.97**	**1.12**
Alabama	1.10	0.96	1.11
Alaska	0.81	0.83	1.43
Arizona	1.09	0.79	1.08
Arkansas	1.08	0.86	1.34
California	1.07	0.93	1.13
Colorado	1.05	0.95	1.13
Connecticut	0.98	0.70	1.07
Delaware	0.91	0.88	1.21
District of Columbia	1.03	1.09	1.14
Florida	1.04	0.83	1.22
Georgia	1.04	0.91	1.33
Hawaii	0.78	0.79	1.15
Idaho	0.96	0.91	1.31
Illinois	0.91	0.75	1.20
Indiana	0.91	0.98	1.29
Iowa	0.83	0.90	1.29
Kansas	0.92	0.65	1.30
Kentucky	1.00	0.85	1.26
Louisiana	1.03	0.89	1.67
Maine	0.81	0.94	1.39
Maryland	1.15	1.04	1.09
Massachusetts	**0.99**	**0.75**	**0.96**
Michigan	0.99	1.00	1.06
Minnesota	0.87	0.88	1.15
Mississippi	0.95	1.07	1.47
Missouri	0.95	0.86	1.11
Montana	0.88	0.85	1.33
Nebraska	0.86	0.97	1.30
Nevada	1.00	1.01	1.20
New Hampshire	0.92	0.74	1.23
New Jersey	0.93	0.90	1.14
New Mexico	1.09	1.11	1.14
New York	1.04	1.05	0.97
North Carolina	1.01	0.93	1.25
North Dakota	0.88	0.96	1.28
Ohio	0.95	0.94	1.13
Oklahoma	1.03	0.70	1.22
Oregon	0.98	0.93	1.10
Pennsylvania	1.02	0.77	1.01
Rhode Island	1.11	1.05	0.92
South Carolina	0.97	0.91	1.43
South Dakota	0.80	0.91	1.37
Tennessee	1.11	0.74	1.18
Texas	1.01	1.06	1.22
Utah	0.99	1.10	1.20
Vermont	0.80	0.87	1.22
Virginia	1.02	1.02	1.31
Washington	1.02	0.96	1.05
West Virginia	0.94	0.89	1.34
Wisconsin	0.89	0.78	1.25
Wyoming	0.90	0.87	1.43

Source: MedPAC, Report to Congress: Medicare Payment Policy, March 2001.
Note: This is an analysis of the American Hospital Association Annual Survey data, 1999, for community hospitals. Managed care revenue for Medicare and Medicaid are included in the private payer category. Medicare data was estimated using "gains and losses as a percent of total hospital costs, by payer and state,

FIGURE 2:

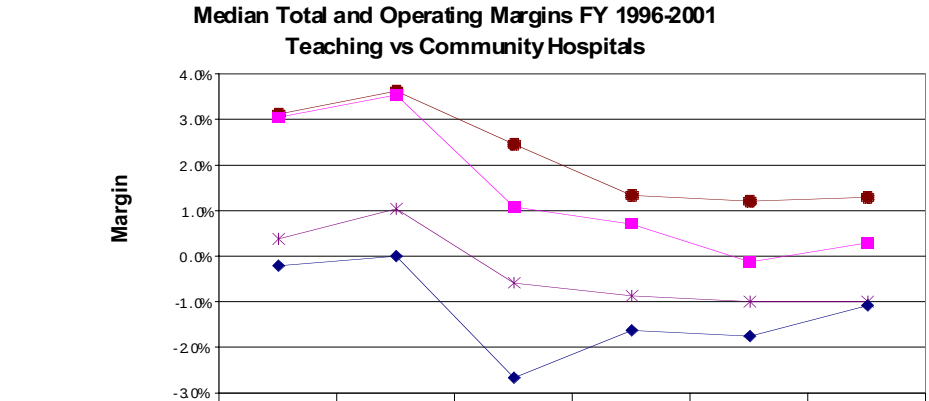


	1997	1998	1999	2000	Q3 2001
Fallon	0.4%	-4.3%	-2.3%	1.1%	4.9%
HMO Blue	3.5%	2.1%	1.7%	2.0%	2.0%
HPHC	1.4%	-0.8%	-8.7%	-0.5%	1.0%
Tufts	2.7%	2.4%	1.4%	3.1%	2.1%

Source: Massachusetts Division of Insurance

- Since 1998, both Fallon and HPHC have experienced negative margins, although their margins have been improving in the last two years.
- All four major health plans had positive margins as of the 3rd quarter of 2001.

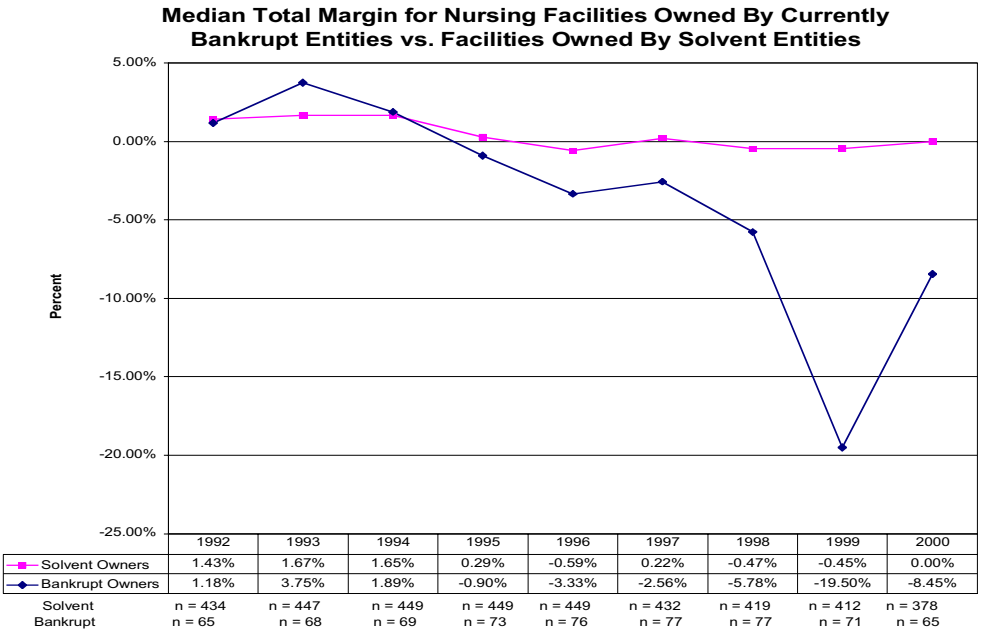
FIGURE 3:



	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01-Q2
Total Community	3.1%	3.6%	2.5%	1.3%	1.2%	1.3%
Total Teaching	3.1%	3.5%	1.1%	0.7%	-0.1%	0.3%
Operating Community	0.4%	1.1%	-0.6%	-0.9%	-1.0%	-1.0%
Operating Teaching	-0.2%	0.0%	-2.7%	-1.6%	-1.8%	-1.1%

Source: DHCFP-403 cost reports; FY 01-Q2 from Mass Hospital Association Financial and Utilization Survey.
Median hospital margins have remained low for several years. Community hospital median margins have remained higher than teaching hospital medians, although individual teaching hospital's performance may far exceed that of most community hospitals.

FIGURE 4:

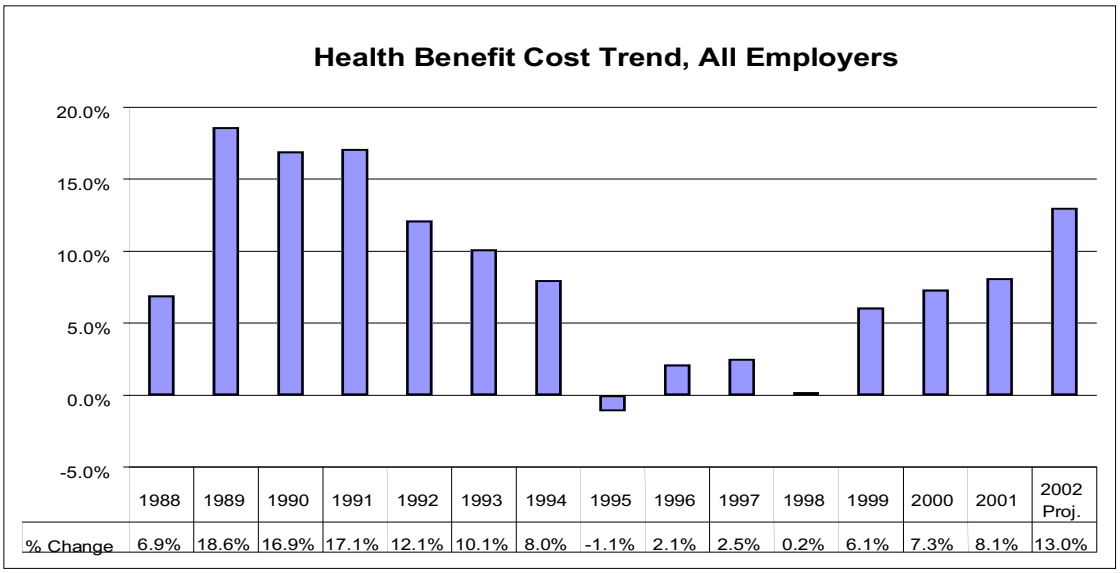


	1992	1993	1994	1995	1996	1997	1998	1999	2000
Solvent Owners	1.43%	1.67%	1.65%	0.29%	-0.59%	0.22%	-0.47%	-0.45%	0.00%
Bankrupt Owners	1.18%	3.75%	1.89%	-0.90%	-3.33%	-2.56%	-5.78%	-19.50%	-8.45%
Solvent	n = 434	n = 447	n = 449	n = 449	n = 449	n = 432	n = 419	n = 412	n = 378
Bankrupt	n = 65	n = 68	n = 69	n = 73	n = 76	n = 77	n = 77	n = 71	n = 65

Source: DHCFP

Facilities owned by parent corporations that were in bankruptcy on June 20, 2001 had lower median margins from 1995 through 2000 than facilities with currently solvent owners. The steep decline in 1999 was primarily the result of extremely low margins that year at facilities owned by Sunbridge.

FIGURE 5:

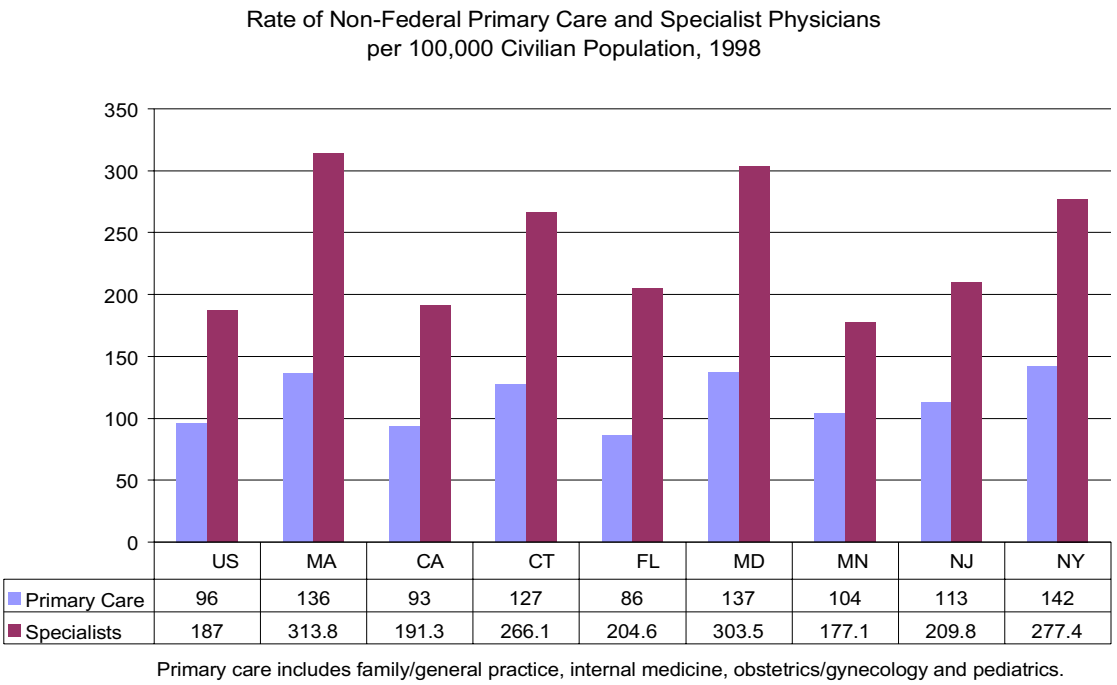


	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002 Proj.
% Change	6.9%	18.6%	16.9%	17.1%	12.1%	10.1%	8.0%	-1.1%	2.1%	2.5%	0.2%	6.1%	7.3%	8.1%	13.0%

Source: William M. Mercer, Incorporated

Employer health care costs increased rapidly in the early 1990's, leveled off in the middle of the decade, and now have begun to rise again.

FIGURE 6:

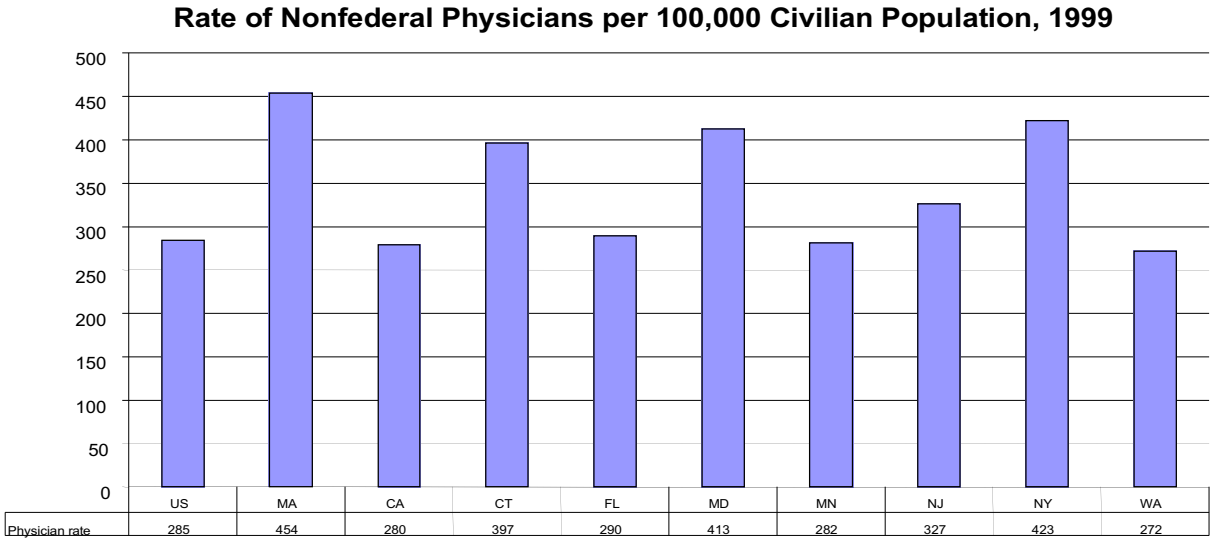


	US	MA	CA	CT	FL	MD	MN	NJ	NY
Primary Care	96	136	93	127	86	137	104	113	142
Specialists	187	313.8	191.3	266.1	204.6	303.5	177.1	209.8	277.4

Primary care includes family/general practice, internal medicine, obstetrics/gynecology and pediatrics.

Source: AMA, taken from www.statehealthfacts.kff.org
Massachusetts ranks 1st in number of specialists per capita and 3rd in number of primary care physicians per capita relative to all states.

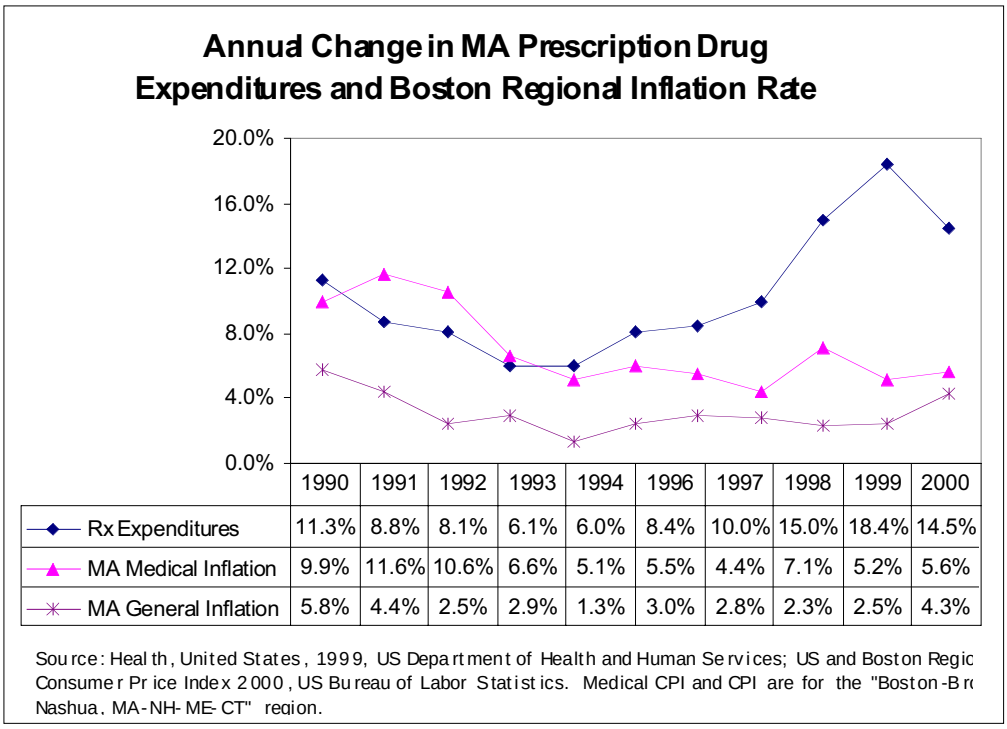
FIGURE 7:



	US	MA	CA	CT	FL	MD	MN	NJ	NY	WA
Physician rate	285	454	280	397	290	413	282	327	423	272

Source: AMA, taken from www.statehealthfacts.kff.org
Massachusetts has more physicans per capita than any other state in the nation.

FIGURE 8:

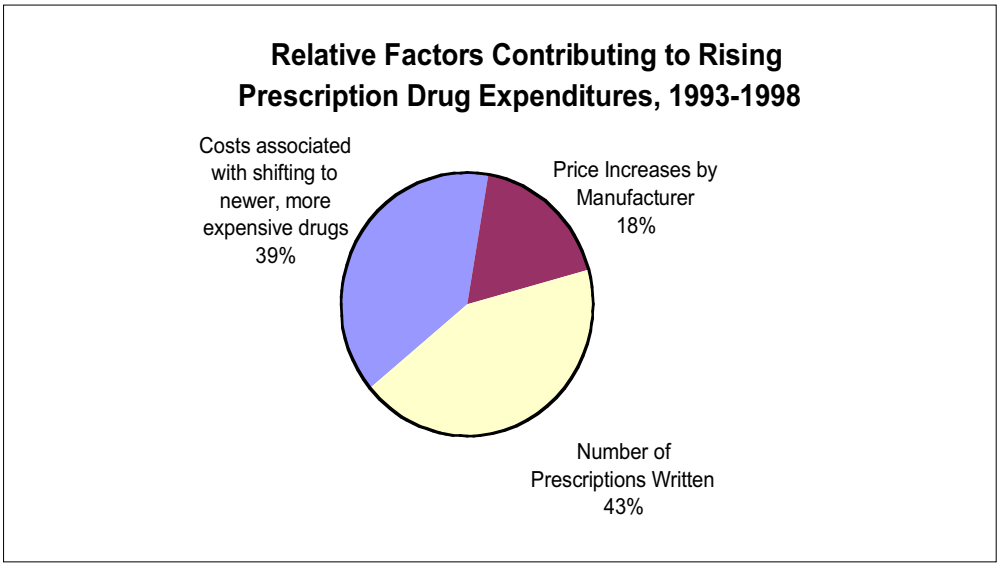


	1990	1991	1992	1993	1994	1996	1997	1998	1999	2000
Rx Expenditures	11.3%	8.8%	8.1%	6.1%	6.0%	8.4%	10.0%	15.0%	18.4%	14.5%
MA Medical Inflation	9.9%	11.6%	10.6%	6.6%	5.1%	5.5%	4.4%	7.1%	5.2%	5.6%
MA General Inflation	5.8%	4.4%	2.5%	2.9%	1.3%	3.0%	2.8%	2.3%	2.5%	4.3%

Source: Health, United States, 1999, US Department of Health and Human Services; US and Boston Regic Consumer Price Index 2000, US Bureau of Labor Statistics. Medical CPI and CPI are for the "Boston-Br Nashua, MA-NH-ME-CT" region.

Throughout the 1990's Massachusetts prescription drug costs increased faster than general inflation, from 1994 through 1998, prescription drug expenditures also increased faster than medical inflation.

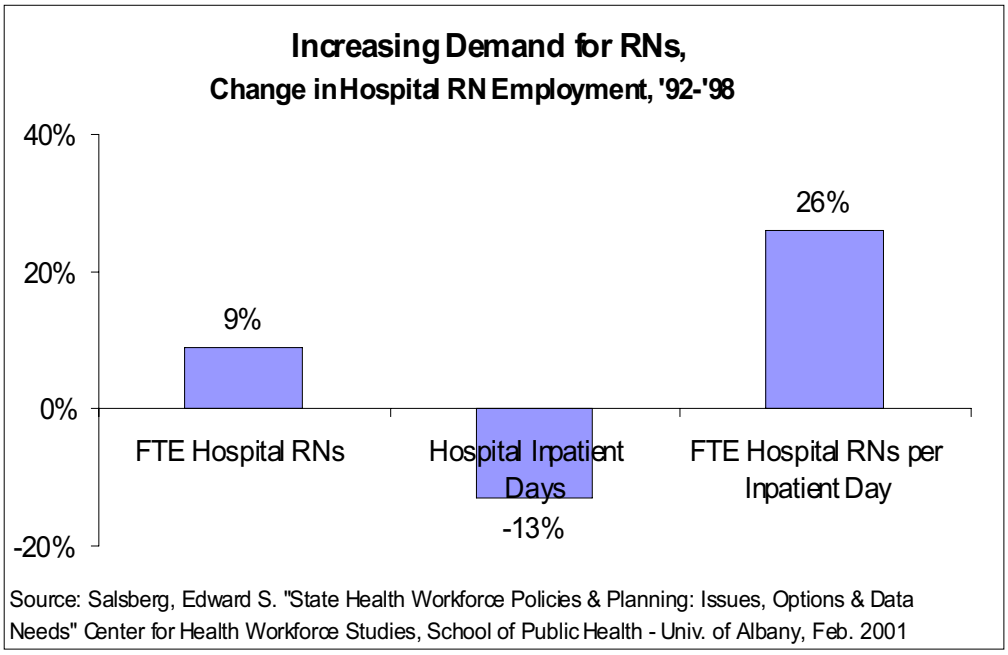
FIGURE 9:



Source: Kreling, David H., et. al. Prescription Drug Trends, A Chartbook. University of Wisconsin - Madison and the Kaiser Family Foundation. July 2000.

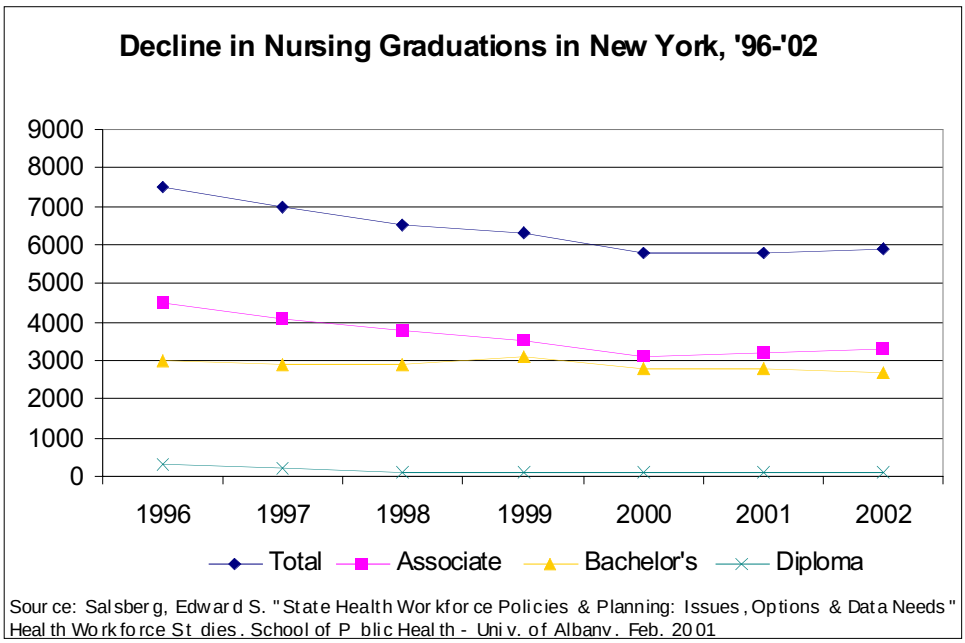
Only 18% of the increase in prescription drug expenditures is attributable to price increases. 43% is attributable to an increase in the number of prescriptions written, and 39% is attributable to the availability of newer and more expensive drugs. Many, but not all, of these new drugs are more effective or have fewer side effects than drugs previously available.

FIGURE 10:



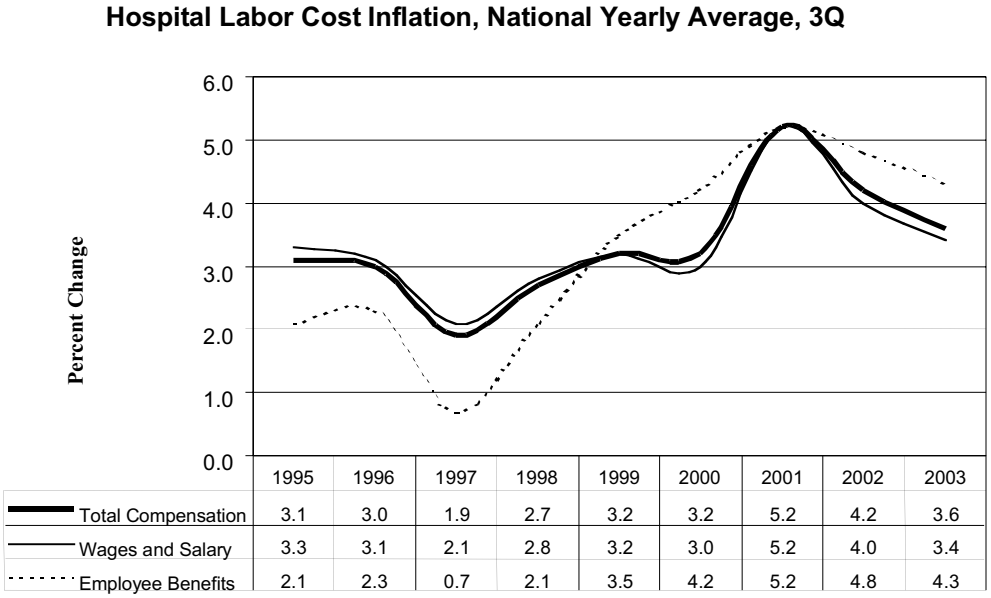
The demand for Registered Nurses increased considerably, despite a decrease in inpatient hospital utilization, between 1992 and 1998.

FIGURE 11:



The number of nursing graduates declined from1996 through 2000 and then plateaued in New York; the trend in Massachusetts is believed to be similar.
The increased demand for nurses, together with the decreased supply, has created a nursing shortage.

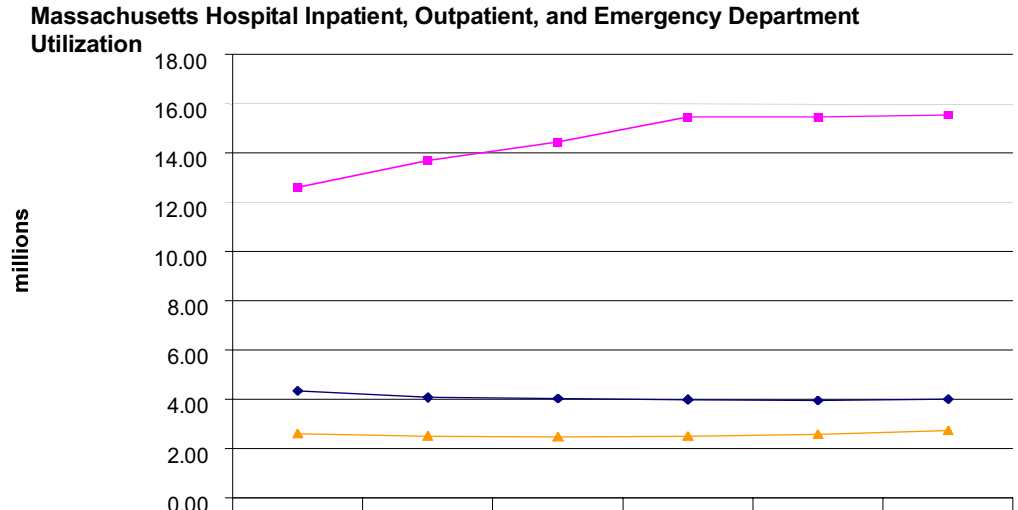
FIGURE 12:



	1995	1996	1997	1998	1999	2000	2001	2002	2003
Total Compensation	3.1	3.0	1.9	2.7	3.2	3.2	5.2	4.2	3.6
Wages and Salary	3.3	3.1	2.1	2.8	3.2	3.0	5.2	4.0	3.4
Employee Benefits	2.1	2.3	0.7	2.1	3.5	4.2	5.2	4.8	4.3

Source: Health Care Cost Review: Third-Quarter 2001, DRI
Although labor cost inflation is projected to decrease beyond 3Q 2001, the average yearly inflation in total compensation increased from 1.9% in 1997 to 5.2% in 2001. Hospitals increasingly offered greater benefits per year to supplement wages and salaries, up from a 0.7% inflation in 1997 to 5.2% in 2001.

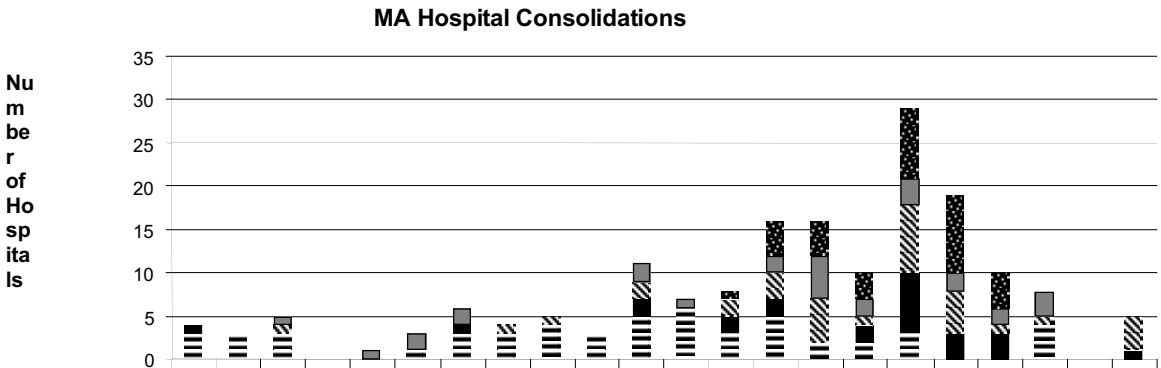
FIGURE 13:



	FY95	FY96	FY97	FY98	FY99	FY00
Total Outpatient Visits	12.60	13.69	14.45	15.46	15.45	15.55
Patient Days	4.34	4.07	4.03	3.99	3.95	3.99
ED Visits	2.60	2.50	2.48	2.49	2.58	2.73

Source: DHCFP 403-cost reports
Hospital outpatient visits continue to increase, while inpatient days are holding steady.
Emergency Department visits declined in the mid-90's, but more recently have begun to rise again. The increase may be due to factors such as the low uninsurance rate, reduced availability of extended hours at physician offices, and the implementation of the "prudent layperson" standard for coverage of emergency visits.

FIGURE 14:

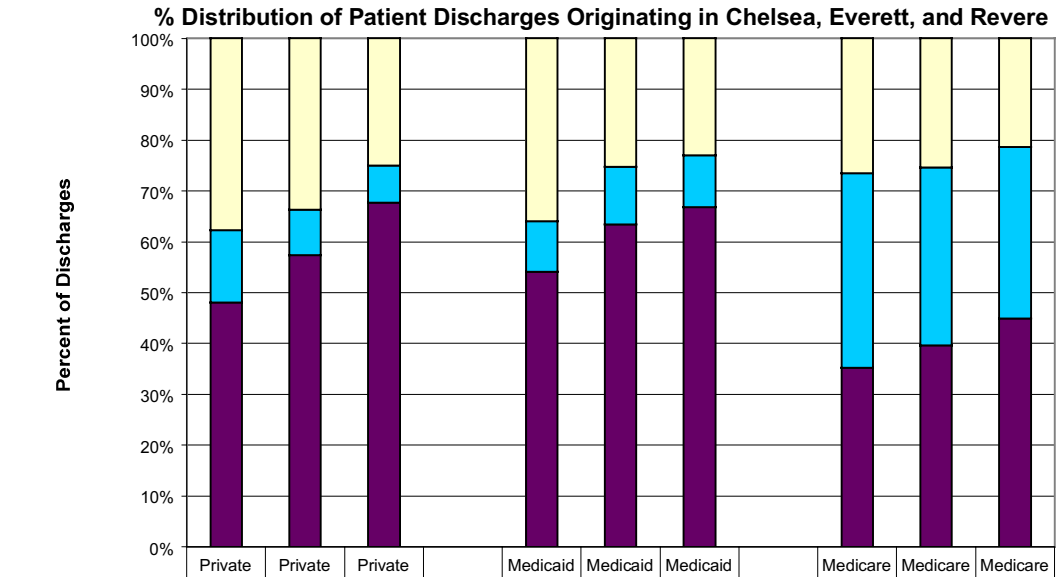


	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Contractual Affiliations	0	0	0	0	0	0	0	0	0	0	0	0	1	4	4	3	8	9	4	0	0	0
Holding Company Affiliations	0	0	1	0	1	2	2	0	0	0	2	1	0	2	5	2	3	2	2	3	0	0
Acquisitions	0	0	1	0	0	0	0	1	1	0	2	0	2	3	5	1	8	5	1	1	0	4
Mergers	1	0	0	0	0	0	1	0	0	0	2	0	2	2	0	2	7	3	3	0	0	1
Closures (Conversions)	3	3	3	0	0	1	3	3	4	3	5	6	3	5	2	2	3	0	0	4	0	0

Source: Massachusetts Hospital Closures/Conversions, Mergers, Acquisition: 1980-Present, MHA, 1999 (Note: 2000-2001 data from DHCFP)

The organization of Massachusetts hospitals experienced a large number of consolidations during the past two decades. This reorganization was marked by 39 closures in ten years (1986-1996) and 33 contractual affiliations since 1992. The consolidation rate has slowed in the last few years.

FIGURE 15:



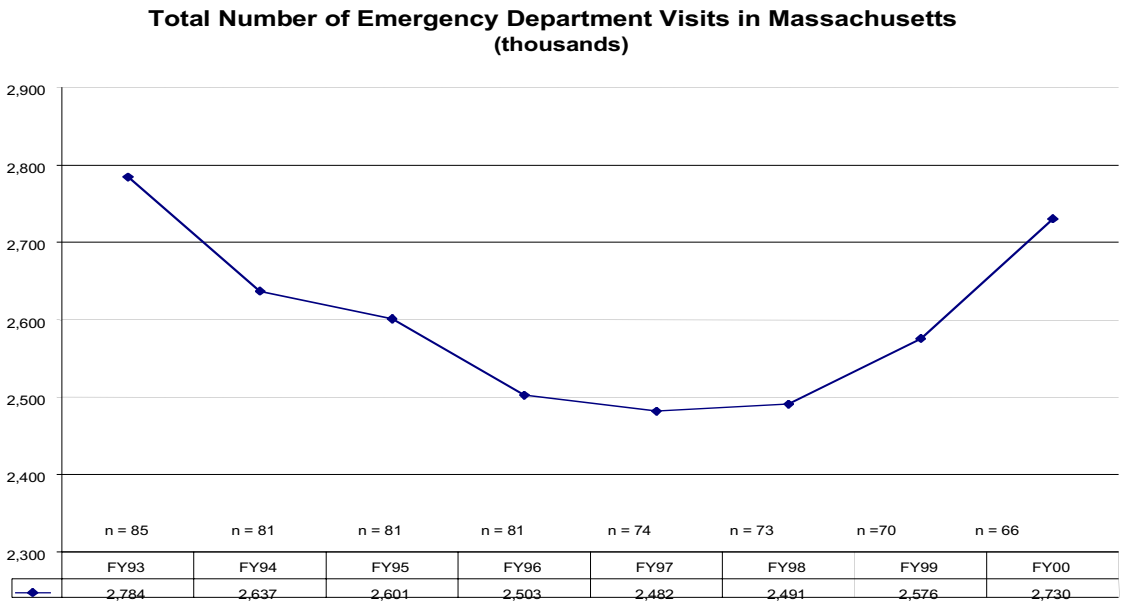
	Private '90	Private '95	Private '99		Medicaid '90	Medicaid '95	Medicaid '99		Medicare '90	Medicare '95	Medicare '99
Community Hospitals	37.8%	33.7%	25.0%		35.9%	25.2%	23.0%		26.6%	25.3%	21.4%
Whidden	14.2%	9.0%	7.3%		10.0%	11.4%	10.1%		38.2%	35.0%	33.7%
Teaching Hospitals	48.1%	57.4%	67.8%		54.1%	63.4%	66.8%		35.2%	39.7%	44.9%

Medicaid category also includes worker's comp, self-pay, uninsured, and other govt. Medicare Managed Care included in Medicare and Medicaid Managed Care included in Medicaid.

Source: DHCFP merged discharge and casemix dataset

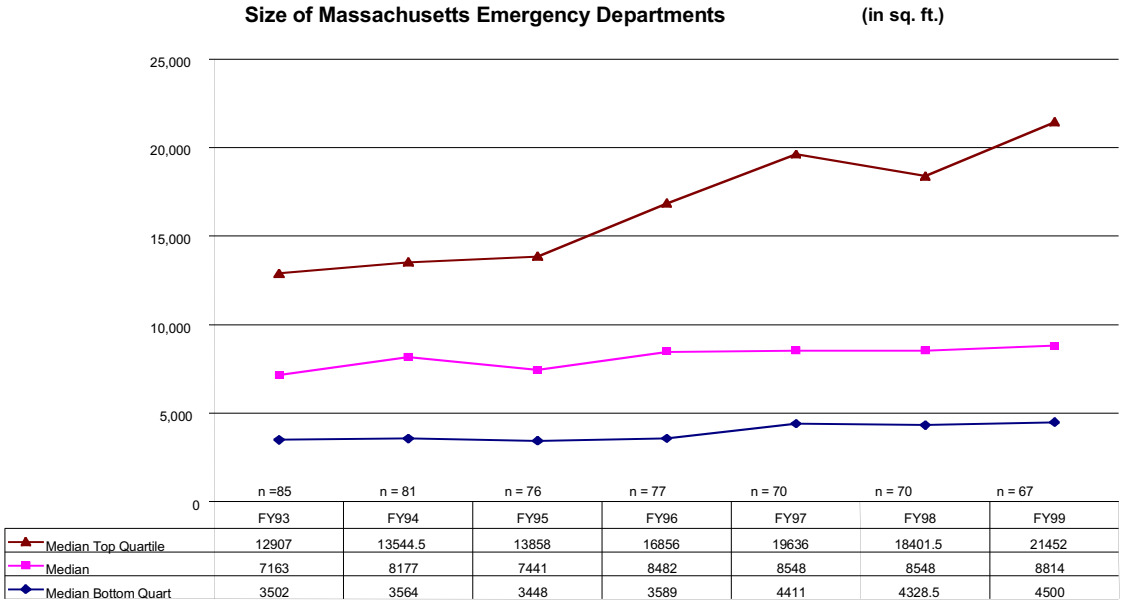
The Whidden case study provides an example of utilization moving from community hospitals to teaching hospitals. From 1990 to 1999 patients from Chelsea, Everett and Revere used Whidden and other area community hospitals much less frequently, and used teaching hospitals slightly more. This trend was particularly evident among private patients.

FIGURE 16:



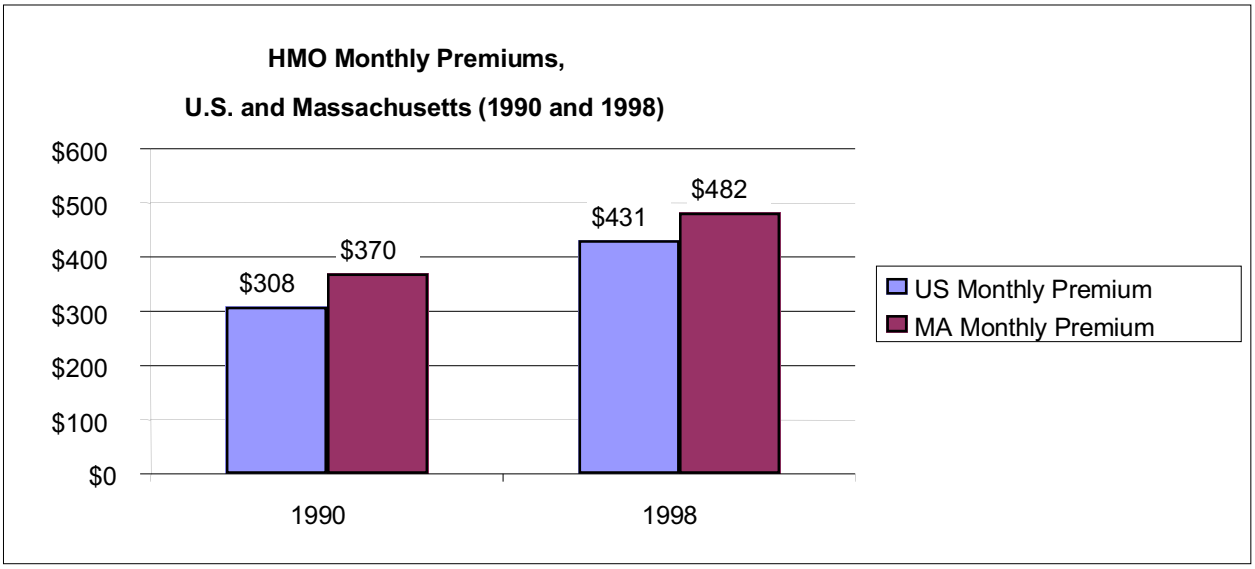
Source: DHCFP-403 cost reports.
The number of emergency department visits declined in the middle of the decade, matching the decline in the number of emergency departments. More recently, emergency visits have increased, but the number of emergency departments has continued to decline.

FIGURE 17:



Source: DCHFP-403 cost reports.
Hospitals with the largest emergency departments have responded to the increased demand by further increasing the size of their emergency departments.

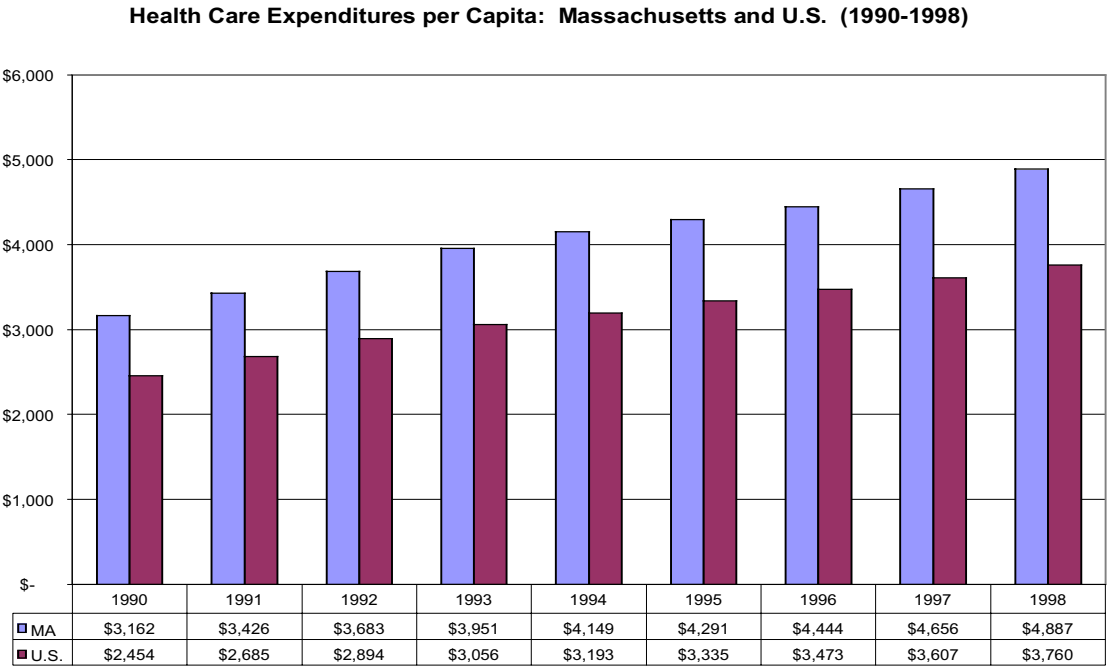
FIGURE 18:



Sources: U.S. Department of Health and Human Services, *Health, United States, 1999*; DCHFP, *HMO Rate Analysis: 1998 Spending, Unit Cost and Utilization* and *Premium Trends for Six HMOs in MA: 1990-1994.* In DHCFP, *Massachusetts Health Care Trends: 1990-1999.*

Massachusetts monthly premiums have consistently exceeded U.S. averages; however MA premiums have increased more slowly than the nation as a whole.

FIGURE 19:

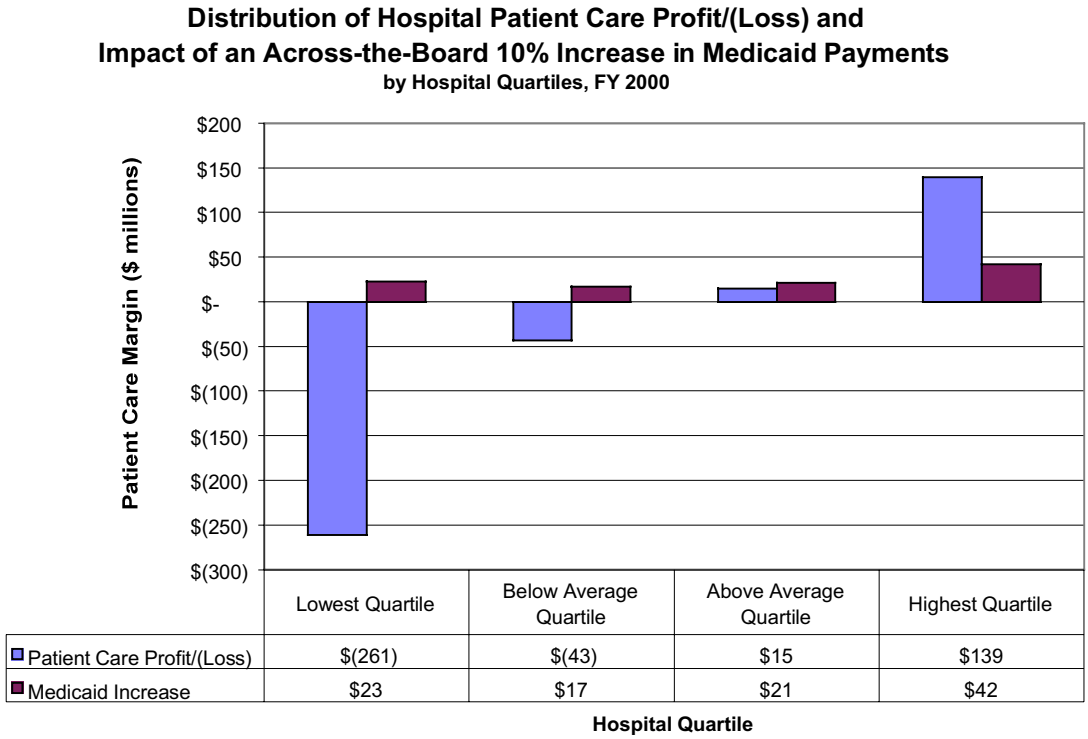


	1990	1991	1992	1993	1994	1995	1996	1997	1998
MA	$3,162	$3,426	$3,683	$3,951	$4,149	$4,291	$4,444	$4,656	$4,887
U.S.	$2,454	$2,685	$2,894	$3,056	$3,193	$3,335	$3,473	$3,607	$3,760

Source: HCFA, Office of the Actuary, National Health Statistics Group, "Massachusetts Health Expenditures, 1989-98," July 17, 2000. In DHCFP, Massachusetts Health Care Trends: 1990-1999. Figures are not adjusted for inflation.

Per Capita health care spending in Massachusetts increased slightly faster than the national average.

FIGURE 20:



Source: DHCFP

For this analysis, hospitals were ranked by their percent margin on their patient care business, and divided into four equal size groups, or quartiles. The blue (or light shaded) bars represent the total patient care profits or losses for each group of hospitals. The maroon (dark) bars represent the total amount medicaid would pay to that group of hospitals if it implemented a 10% increase in payment rates across the board.

This analysis indicates that an across the board medicaid increase would help financially robust hospitals more than distressed hospitals, and would not substantially ease financial distress for the worst off hospitals.

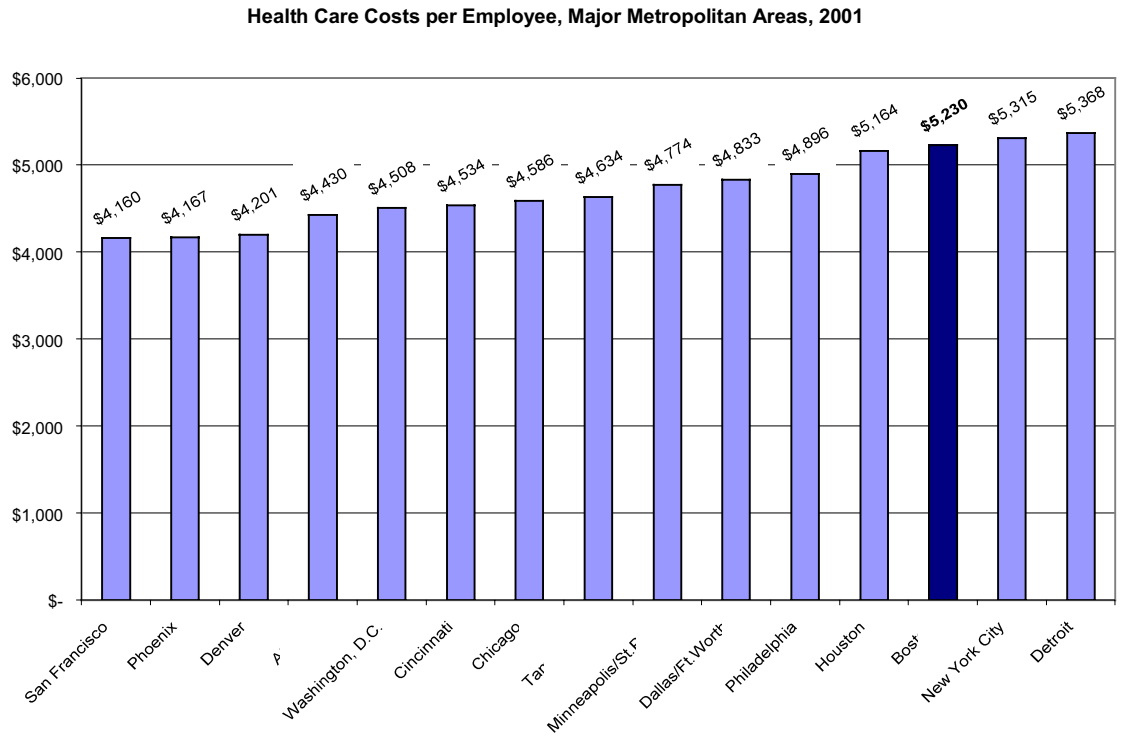
NOTES:

Medicaid increases were estimated by multiplying .10 by medicaid net patient service revenues reported on DHCFP-403 cost reports.

Boston Medical Center and Cambridge Health Alliance were excluded from this analysis because as their Medicaid payments are structured very differently from other hospitals', as a result of their disproportionate share status and their medicaid managed care programs.

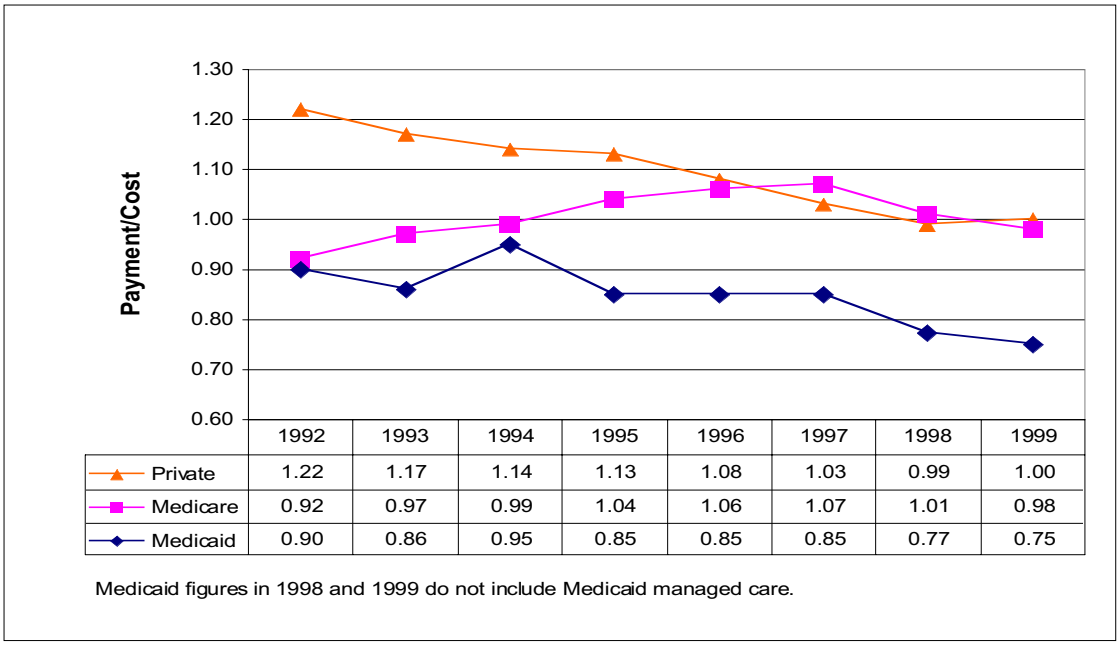
Falmouth Hospital was excluded from this analysis because of data issues.

FIGURE 21:



Source: Hewitt Associates, Hewitt Health Value Initiative, 2001.
Boston area employers are faced with higher employee health care costs than employers in most other major metropolitan areas.

FIGURE 22:



	1992	1993	1994	1995	1996	1997	1998	1999
Private	1.22	1.17	1.14	1.13	1.08	1.03	0.99	1.00
Medicare	0.92	0.97	0.99	1.04	1.06	1.07	1.01	0.98
Medicaid	0.90	0.86	0.95	0.85	0.85	0.85	0.77	0.75

Medicaid figures in 1998 and 1999 do not include Medicaid managed care.

Sources: 1992-1998 from "Analysis of the Reimbursement Rates for Acute Hospitals, Non-Acute Hospitals, and Community Health Centers", The Lewin Group, Inc., June 25, 2001, p.35.
1999 and Medicaid 1998 from MedPAC, Report to Congress: Medicare Payment Policy, March 2001.

Private payment levels to hospitals declined throughout the 1990's, relative to costs. Payment levels from all three major payers have declined in the last several years.

FIGURE 23:
Calculation of Medicaid Cost Adjustment Factor for Acute Hospital Operating Expenses

(1)	(2)	(3)	(4)	(5)
Cost Category	**Index Used**	**Category Weight**	**Percent Change in Average Price Level**	**Weighted Percent Change** (C.3*C.4)/100
Labor	Massachusetts Consumer Price Index, Lowest Likely Forecast	71.06	1.40%	1.00%
Non-Labor	16 separate indices tracking items such as rubber and plastic products, prescription drugs, industrial chemicals, processed foods, etc.	28.93	0.53%	0.15%
Sum of Components (FY 02 Update Factor)				1.15%

Source: DHCFP
Note that while non-labor prices increased an average of .53%, some indices increased by more than 2%, while others increased at a lower rate, and others decreased.

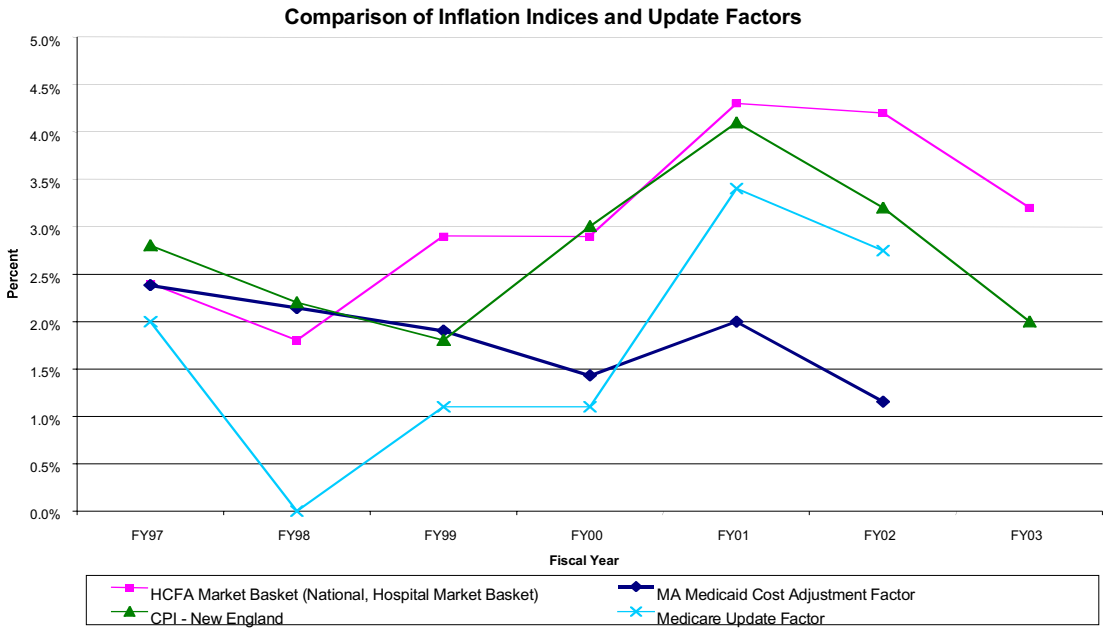
FIGURE 24:

Update Framework for Inpatient Hospital Payment Rates, Combining Operating and Capital Payments, FY 2002	
Component	**Percent**
Factors affecting the current level of payments:	
Correction for FY 2000 market basket forecast error	0.7
Unbundling of the payment unit	-2.0 to –1.0
Coding changes across service categories	0
Complexity changes within service categories	0
Medicare policy changes affecting financial status	0
Factors expected to affect provider costs next year:	
Forecast of input price inflation	2.8
Scientific and technological advances net of productivity growth and one-time factors	0 to 0.5
Sum of Components	1.5 to 3.0 (MB – 1.3 to MB + 0.2)

Source: MedPAC, Report to the Congress: Medicare Payment Policy, March, 2001, p.73.

MedPAC uses the methodology summarized in this table to develop its recommended update factor for Medicare inpatient hospital payment rates (operating cost component). MedPAC recommends the update factor to Congress; Congress may approve the recommended update factor or adjust it.

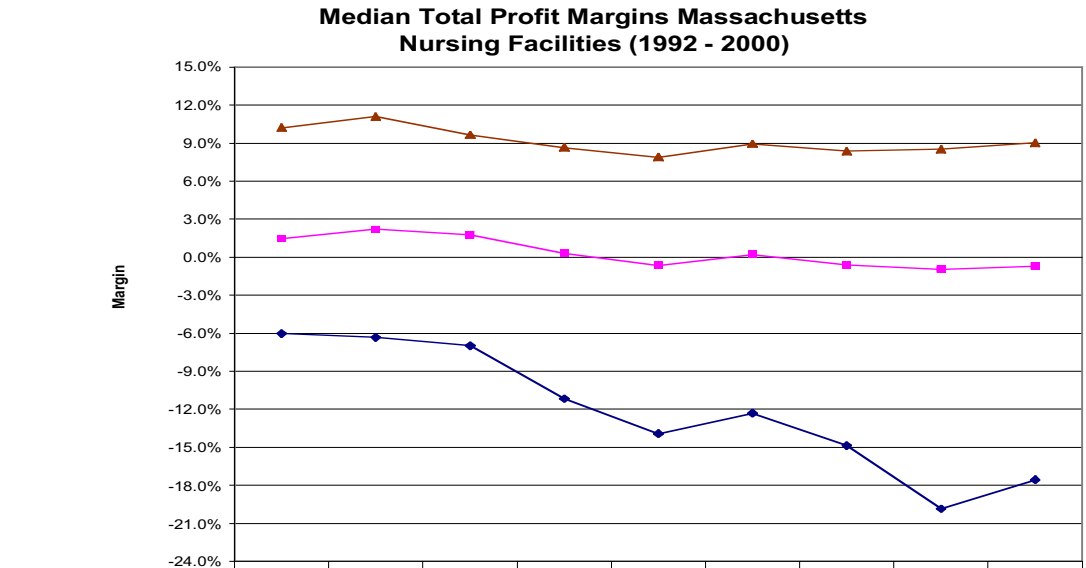
FIGURE 25: MEDICAID RFA & MEDICARE UPDATE FACTORS



Massachusetts Medicaid hospital cost adjustment factor declined slowly over the last five years. During this same period, the HCFA hospital market basket (a measure of hospital input prices) declined slightly and then increased sharply, as did the New England region Consumer Price Index. The Medicare hospital update factor tracked the hospital market basket, but remained below it.

The Medicare and Medicaid factors shown here are for operating costs only.

FIGURE 26:



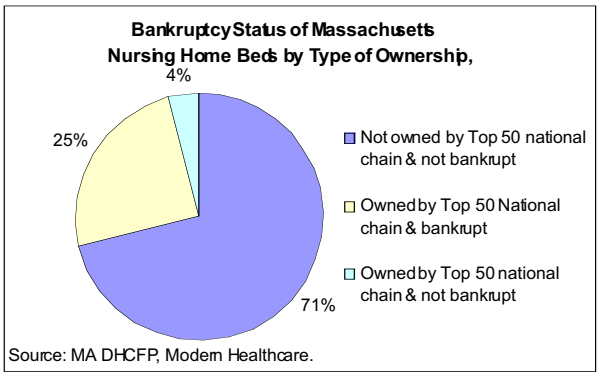
	1992	1993	1994	1995	1996	1997	1998	1999	2000
Median for Highest 25%	10.2%	11.1%	9.6%	8.7%	7.9%	8.9%	8.4%	8.5%	9.0%
Median for All	1.5%	2.2%	1.8%	0.3%	-0.6%	0.2%	-0.6%	-0.9%	-0.7%
Median for Lowest 25%	-6.0%	-6.3%	-7.0%	-11.2%	-13.9%	-12.3%	-14.9%	-19.9%	-17.6%
	n = 474	n = 499	n=492	n=495	n=491	n=479	n=474	n = 470	n = 484

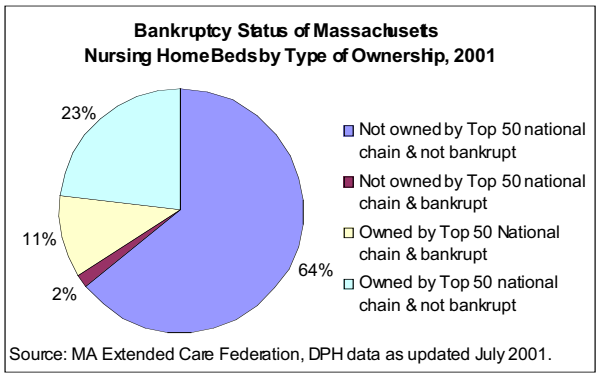
Source: DHCFP

Margins for the top 75% of nursing facilities have remained relatively stable for several years, increasing slightly in 2000. The median margin in 2000 was slightly below break-even. The top 25% of facilities had strong positive margins from 1992-2000. The lowest 25% of facilities had increasingly negative margins from 1994 through 1999, improving somewhat in 2000. The steep decline in margins of the lowest quartile in 1999 is due almost entirely to extremely low margins at facilities owned by one bankrupt chain (Sunbridge); if those facilities are removed, there is little change in median margin for the lowest quartile from 1998 through 2000.

This analysis reports medians, rather than means, as a better measure of an "average" facility because the data are very skewed. That is, there are a small number of facilities with very high costs and revenues that would inflate a mean, but not a median.

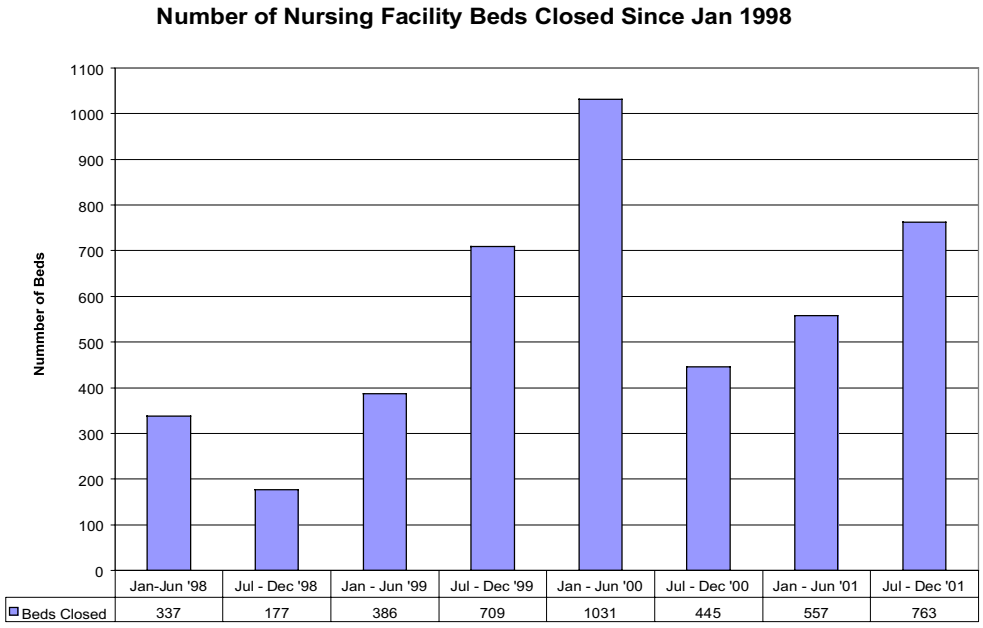
FIGURE 27:





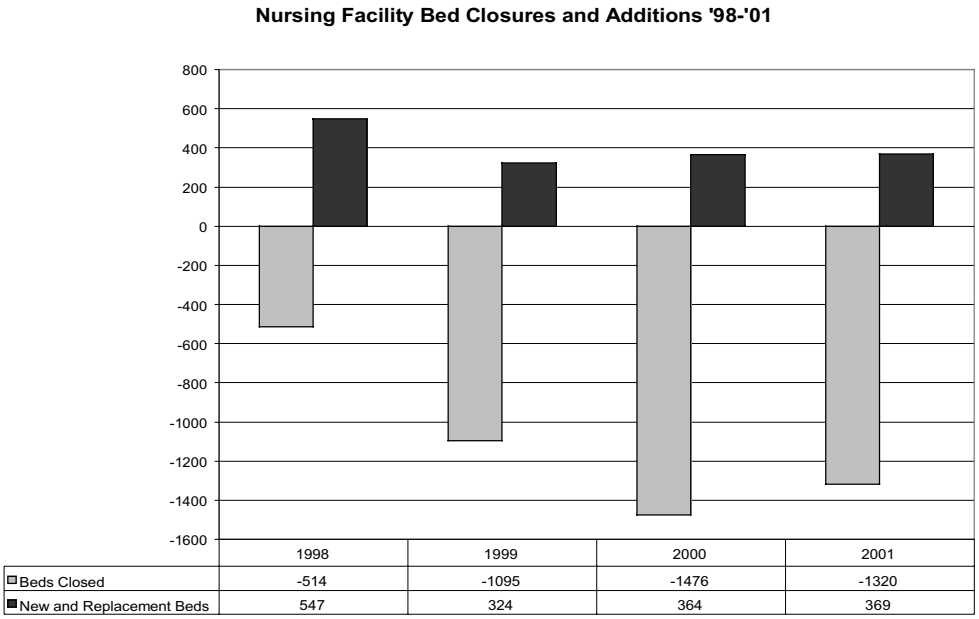
Source: [date needed]
Two large chains, Genesis and Vencor, emerged from bankruptcy. Others have sold or closed some facilities based in Massachusetts. A few local facilities have recently declared bankruptcy.

FIGURE 28:



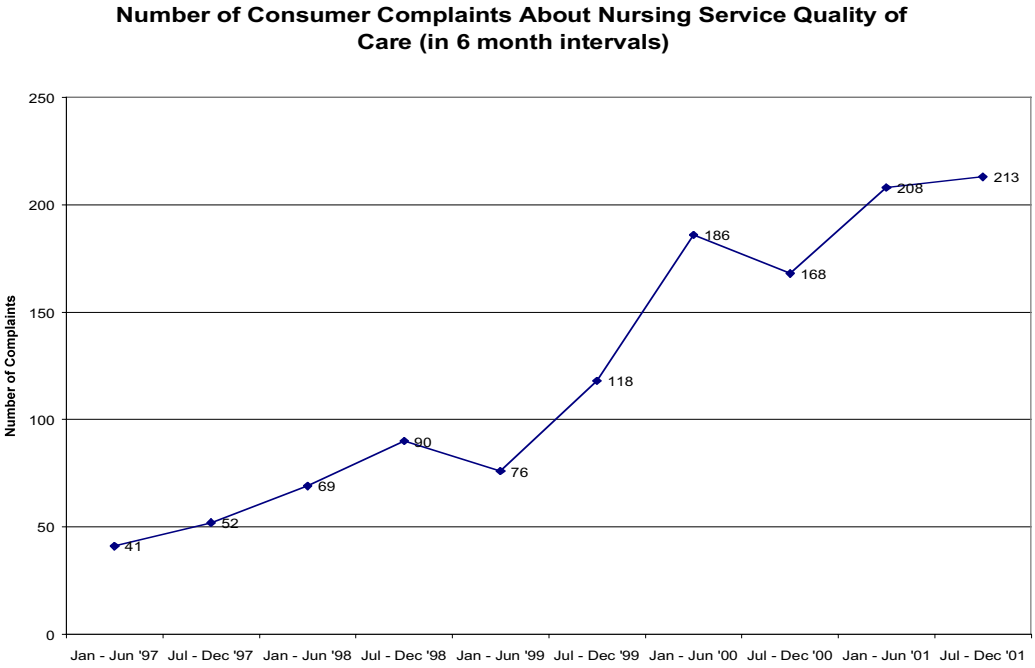
Source: DPH
An increasing number of nursing facility beds have closed in recent years, peaking in early 2000.

FIGURE 29:



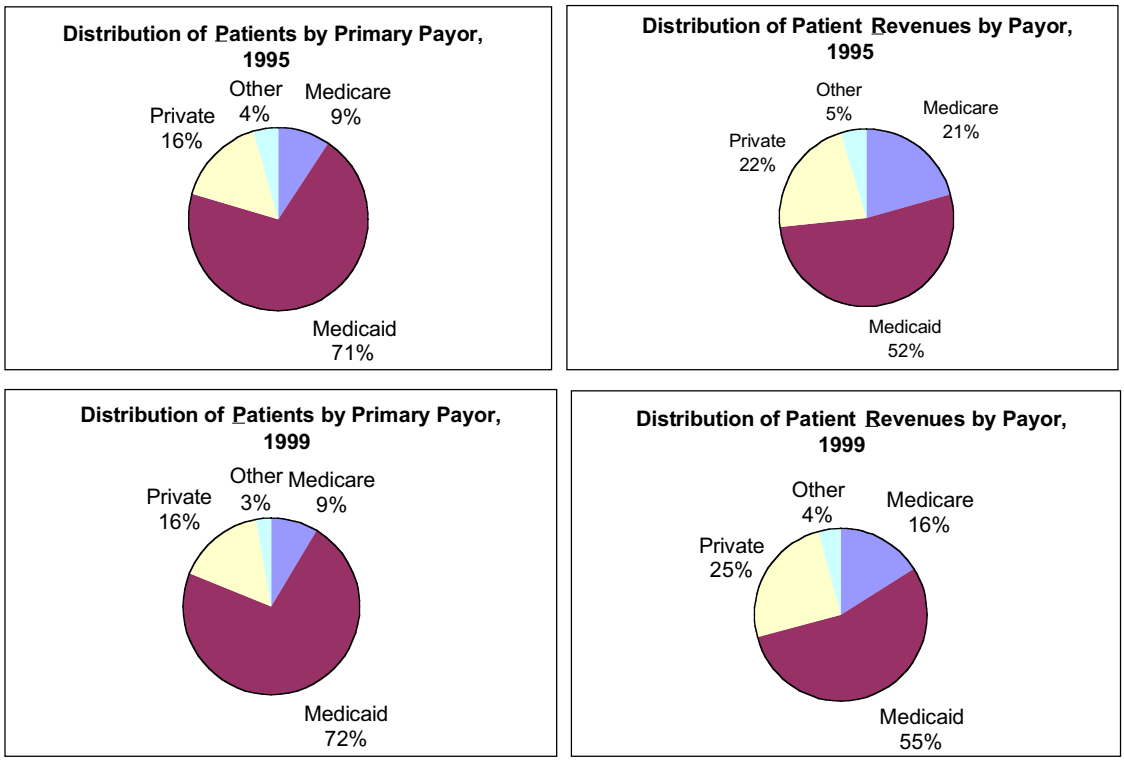
Source: DPH
A small number of new beds have come on line, even as beds are closed elsewhere.
Note: The reported bed closures are not necessarily permanent. Some closures could be due to facility replacement, relocation or renovation.

FIGURE 30:



Source: DPH
The number of complaints to the Department of Public Health regarding the quality of nursing services at nursing facilities increased dramatically in the last several years.

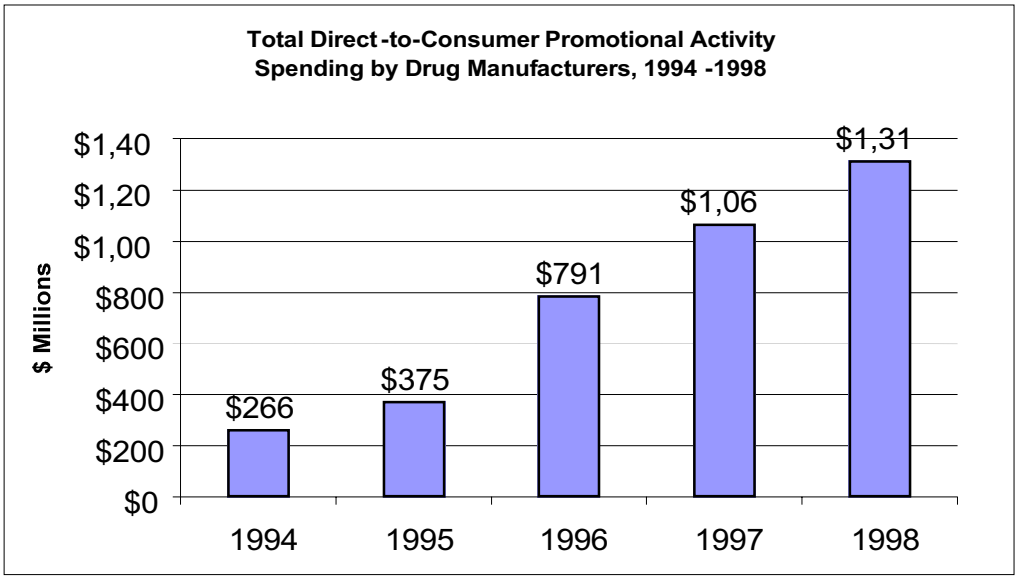
FIGURE 31: Nursing Facility Payer Mix



Source: DHCFP

From 1995 to 1999 the share of patients paid for by each of the major payers did not change significantly, however Medicare's share of total patient revenue dropped from 21% to only 16% as a result of the BBA.

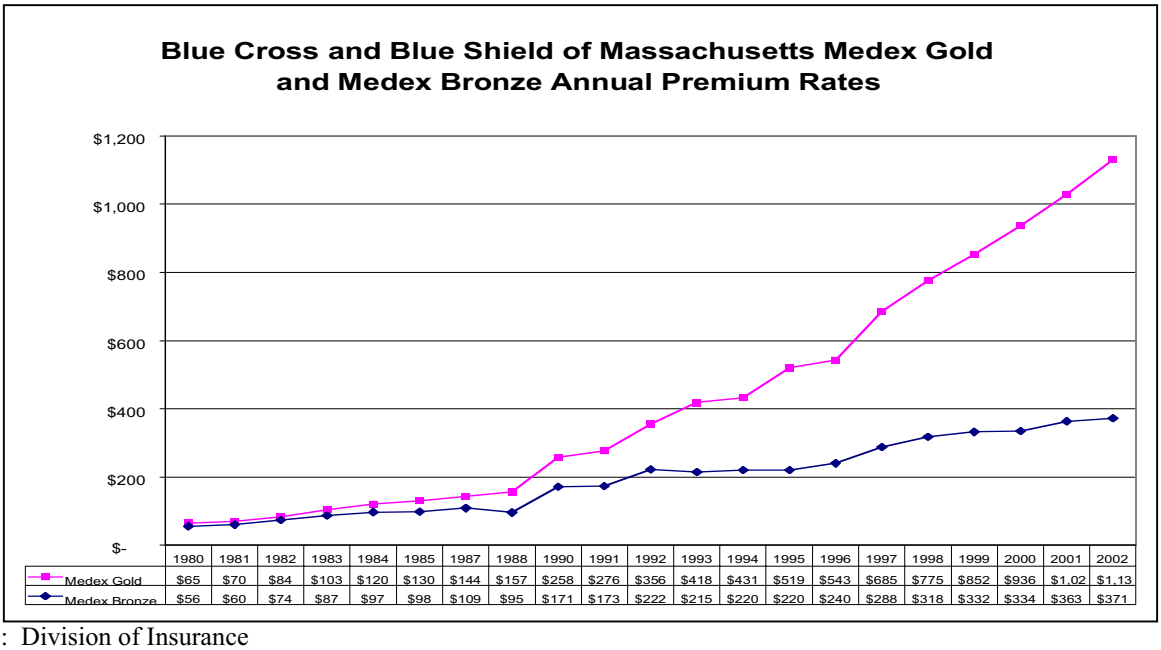
FIGURE 32:



Source: Kreling, David H., et. al. Prescription Drug Trends, A Chartbook. University of Wisconsin - Madison and the Kaiser Family Foundation. July 2000

Drug manufacturers' spending on direct to consumer promotional activities increased rapidly after the U.S. Food and Drug Administration revised guidelines for advertising prescription drugs in 1995.

FIGURE 33:



	1980	1981	1982	1983	1984	1985	1987	1988	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Medex Gold	$65	$70	$84	$103	$120	$130	$144	$157	$258	$276	$356	$418	$431	$519	$543	$685	$775	$852	$936	$1,02	$1,13
Medex Bronze	$56	$60	$74	$87	$97	$98	$109	$95	$171	$173	$222	$215	$220	$220	$240	$288	$318	$332	$334	$363	$371

Source: Division of Insurance

Blue Cross and Blue Shield's Medex Gold and Medex Bronze Medex plans are identical, except that Medex Gold includes drug coverage, while Medex Bronze does not. Medex Gold premiums are increasing much faster than Medex Bronze.